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Montana Morbidity Report

Volume: 13:1 Month of: January, 1989

Montana State Department of Health and Environmental Sciences

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HIV/AIDS INFORMATION

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RESOURCES

AIDS Supplement

The Office of Public Instruction has produced an AIDS Supplement to its Comprehensive Health Curriculum. OPI recommends that instruction about AIDS should be integrated into appropriate health instruction units rather than be taught as a separate K-12 AIDS education curriculum.

To obtain a copy of the guideline, contact Laurie Volesky, AIDS Education Specialist, at OPI.

Clinical and Laboratory Features of HIV Infection

Abbott Diagnostics Educational Services has produced a monograph on HIV infection entitled "Clinical and Laboratory Features of HIV Infection." The information in the booklet was excerpted from materials collected for the National Academy of Sciences. This monograph presents guidelines to diagnosis, including antibody testing and treatment of AIDS-related infections. Co-authors of the monograph include Constance Wofsy, M.D., Paul Volberding, M.D., and Lawrence Kaplan, M.D. The monograph is free and available by writing to: Abbott Diagnostics, Division of Abbott Laboratories, Abbott Park, IL 60064.

RESEARCH

Surveillance of HCW Exposed to HIV Infected Blood

Abstract: Since 1983 the CDC has conducted national surveillance of health care workers exposed to blood or body fluids from persons infected with the human immunodeficiency virus (HIV), to assess the risk of HIV transmission by such exposures. As of July 31, 1988, 1,201 health care workers with blood exposures had been examined, including 751 nurses (63 percent), 164 physicians and medical students (14 percent), 134 laboratory workers (11 percent), and 90 phlebotomists (7 percent).

The exposures resulted from needle-stick injuries (80 percent), cuts with sharp objects (8 percent), open-wound contamination (7 percent), and mucous-membrane exposure (5 percent). It was concluded that 37 percent of the exposures might have been prevented.

Of 963 health care workers whose serum has been tested for HIV antibody at least 180 days after exposure, 4 were positive, yielding a seroprevalence rate of 0.42 percent (upper limit of 95 percent confidence interval, 0.95 percent). Three subjects experienced an acute retroviral syndrome associated with documented seroconversion; serum collected within 30 days of exposure was not available from the fourth person. Two exposures that resulted in seroconversion were caused by co-workers during resuscitation procedures.

They conclude that the risk of HIV infection after exposure to the blood of a patient infected with HIV is low, but at least six months of follow-up is recommended. Many exposures can be prevented by careful adherence to existing infection-control precautions, even during emergencies.

(Marcus R, and the CDC Cooperative Needlestick Surveillance Group. New England Journal of Medicine 1988; 319:1118-23.)

Live Virus Vaccines in HIV Infected Children

Can live virus vaccines be used safely in children infected with human immunodeficiency virus (HIV)? The question has assumed urgency with HIV infection having become a significant cause of serious immunodeficiency in children. During the five-year period from 1981 to 1986, 410 cases of acquired immunodeficiency syndrome (AIDS), the most severe form of HIV infection, were reported nationally in children younger than 13 years of age. Clinicians estimate the number of children either with less severe manifestations of HIV infection or presently asymptomatic infection to be three times that of AIDS patients.

Live virus vaccines have the potential to cause serious adverse reactions when administered to immunocompromised patients because the immune defects may allow excessive viral replication. Since children infected with HIV may be immunosuppressed, clinicians have been concerned about the immunization of these children, whether symptomatic or asymptomatic, with live virus vaccines -- specifically, trivalent or polio vaccine (OPV), individual measles, mumps, and rubella antigen, and combined measles, mumps and rubella (MMR) vaccines.

To address this concern, the New York City Department of Health, in consultation with the Centers for Disease Control, conducted a retrospective chart review survey to examine serious adverse events related to receipt of live virus vaccine by HIV-infected children. Outpatient records of 319 of the estimated 700 children with symptomatic or asymptomatic HIV infection receiving pediatric care in New York City and New Jersey were reviewed. Of these, 221 records contained the child's immunization history and age at the presumed time of acquisition of HIV infection. Of the 221 children, 71 had AIDS, 133 had AIDS-related illness, 17 were asymptomatic, and 41 died. There were 538 live vaccine doses administered to these 221 HIV-infected children. At least one dose of live OPV had been given to 180 children; 70 had received MMR vaccine. The temporal relationship of vaccination to the onset of symptoms of immunodeficiency was available for 120 children; 46 of 120 had received at least one dose of OPV and 23 of 45 had been given MMR after onset of symptoms.

No serious adverse events were described in the outpatient records. There were no reports of serious sequelae such as typical or atypical measles, paralytic poliomyelitis, or aseptic meningitis in the month following vaccination.

The researchers note that their data indicating that serious adverse sequelae have not occurred in HIV-infected children are supported by the New York City and New Jersey departments of health surveillance for adverse vaccine reactions. No increase in vaccine-associated paralysis or measles vaccine-related encephalopathy was found during the past seven years -- a time when HIV infection has been increasing in New York City and New Jersey.

The results of the survey must be qualified by the limitations of the sample size and the retrospective nature of the data. A subtle manifestation of vaccine-associated disease such as a chronic progressive poliomyelitis reported in immunodeficient children might not be different from HIV-related disease. A prospective study is planned to allow for a better assessment of the risks and benefits of immunization for HIV-infected children.

(McLaughlin M, Thomas P, Onorato I, et al. Pediatrics 1988; 82(2):229-233.)

Statistics

Statistics for HIV tests and AIDS cases will be available through the Montana AIDS Hotline beginning March 10, 1989. Montana statistics as well as national statistics can be obtained by calling the toll-free Hotline number: 800-233-MONT (6668).

Effects of HIV Disease on Pregnancy

Women currently account for about 7% of the cumulative number of reported US AIDS cases. HIV disease is transmitted by inoculation of blood and blood products, sexual contact, and maternal-fetal events. Although the majority of AIDS cases in the next few years are still going to be derived from high-risk groups, nearly 10% of the total number of cases will be attributable to heterosexual transmission. Within this group will be an increasing number of children who acquire this infection by perinatal transmission. Perinatal transmission has occurred in 565 (77%) of AIDS cases among children reported to the CDC through December 21, 1987. The rate of perinatal transmission is estimated to be 40-50%. In a one-year interval, 50 patients with HIV infection were followed antepartum, intrapartum, and/or postpartum for a total of 52 pregnancies. All patients had repeatedly positive enzyme immuno assays and/or Western blots for HIV. Mean age at the time of the most recent delivery was 27 years. Cases associated with heterosexual transmission of HIV disease accounted for approximately 76% of the total. More than half the patients were Haitian.

Of the 50 mothers, 15 had uncomplicated antenatal courses (28.8%). Three patients died of complications related to AIDS, two during pregnancy and the third 4 months after delivery. Eight of the patients had pregnancies complicated by premature rupture of membranes; three cases occurred preterm, and these women delivered prematurely. Seventeen patients experienced preterm labor during the course of 18 pregnancies; 16 of the pregnancies resulted in premature deliveries.

Other problems associated with the antepartum course included oligohydramnios, chronic hypertension with eclampsia, fetal death, urinary tract infections, pyelonephritis, herpes simplex, syphilis, and third-trimester vaginal bleeding. Seven patients had urinary tract infection. Three experienced a fetal death. There were 36 vaginal deliveries among 34 patients; two patients became pregnant a second time during the study period. Two of the vaginal deliveries were among three patients who died of complications related to AIDS. Of the 52 pregnancies, there were 16 cesarean sections, including 3 for fetal distress, 3 for cephalopelvic disproportion, 2 for malpresentation, and 1 for macrosomia. Three other cesarean sections were performed for third trimester bleeding, herpes genitalis, or agonal cesarean.

The postpartum course had many more complications. Eight patients had endometritis, 3 had retained placenta, and 2 had prolonged rupture of membranes. Three of the cases also had puerperal febrile morbidity. Two of three patients who died of complications of AIDS were asymptomatic when first seen in the course of their pregnancies. The third patient had already experienced fever and weight loss before becoming pregnant. Four patients were antenatally diagnosed as having oral candidiasis. Within 1 day of delivery, three of the four had T4/T8 ratios ranging from 0.1-0.5 and absolute T-helper cell counts ranging from 16-169 cells/mm^3.

Approximately 24 of the women had associated lymphadenopathy with their underlying HIV disease. Three of these had oral candidiasis during their course of pregnancy. Among the 50 patients, there were 53 deliveries and 49 liveborn neonates in the study period; no neonates had congenital abnormalities. Ten of the patients are known to have children with HIV infection. The patients in this study experienced several complications of pregnancy. About one third experienced infection, including urinary tract infections, syphilis and/or gonorrhea, or herpes simplex. The results of this study suggest a higher rate of infection of the genitourinary tract and an increased incidence of sexually transmitted diseases in women known to be infected with HIV.

(Gloeb DJ, et al: Am J Obstet Gynecol 1988; 159:756-761.)

STD TRAINING COURSES AND OTHER TRAINING

A jointly sponsored venture among state and local health departments, selected medical schools and the Centers for Disease Control has led to the establishment of Sexually Transmitted Diseases (STD) Prevention/Training (P/T) Centers. Medical school faculty and clinic personnel have designed instruction and training for health care providers who work in STD and HIV/AIDS. Medical update seminars are also available to other health and related professionals. Of the 10 centers, the closest are Seattle, Denver or Chicago. If you are interested in an announcement of course dates, locations and registration forms, write STD Program, Cogswell Building, Room C-303, Helena, MT 59620. Limited stipends for travel costs may be available in certain situations. Continuing medical education is available through ACCME. Below are descriptions of the courses:

COMPREHENSIVE: An introductory two week clinical training course for full-time STD clinicians. The course content includes: Introduction to STD, Diagnosis and Management, Patient Interaction, Clinic Record, History and Physical Exam, Laboratory, Therapeutics, Patient Education and Clinic Management. The format includes lectures, discussion, clinical and laboratory experience.

INTENSIVE: An introductory one week clinical training course aimed at STD clinicians. The content is similar to the "Comprehensive" course, but offers limited clinical/laboratory experience.

PART-TIME INTENSIVE: A three day introductory clinical training course aimed at part-time STD clinicians. The course offers a brief overview of STD diagnosis and management.

ADVANCED: A one week course designed for experienced clinicians needing advanced training and for graduates of the "Comprehensive" course having at least 2-4 months of clinical experience. The course format includes:

Review of Diagnosis and Management, Differential Diagnosis, Laboratory, and Clinic Management. The course format includes lectures, problem-solving and clinical and laboratory experience.

CLINICIAN UPDATE: A one or two day seminar for practicing clinicians that includes problem-solving, lectures, consultation time and clinical and laboratory experience.

DISEASE INTERVENTION SPECIALISTS UPDATE: A two or three day seminar for public health advisors, providing an overview of current developments in STD diagnosis and management.

LABORATORY METHODS: A one to three day course for STD personnel performing lab procedures in the clinic. The course content includes didactic and practical lab training in use of the microscope, plating of cultures, reading of Gram stains, wet preps, RPRs, and darkfield specimens.

In addition, the MDHES Communicable Disease Section is tentatively planning a repeat of its two-day course entitled "Communicable Disease Interview/Field Investigation Course" to be held in Billings in late May 1989. Further information will be provided in next month's Montana Morbidity Report.

1988 PROVISIONAL TOTALS COMPARED TO 1987 TOTALS FOR SELECTED DISEASES REPORTED TO MDHES

Data for some diseases are fairly complete now but all 1988 data must be considered provisional until the annual report is generated in March 1989. Some noticeable differences are listed below:

Disease	No. of Cases 1987	No. of Cases 1988
Tuberculosis	21	38
Shigellosis	42	261
Salmonellosis	74	97
Rabies in Animals	185	112
Post-exposure Rabies Treatment	121	95
Hepatitis A	86	47
Gonococcal Disease	619	410
Campylobacter	39	84

EPIINFO - A Communicable Disease Database

Although the annual report of communicable disease case numbers for 1988 won't be available until March, it's possible to take a look at trends for 1988 at this time. Several years ago the Communicable Disease Program began using an electronic database developed by Centers for Disease Control called EPIINFO. EPIINFO is a database and more. We enter information given to us for each case into a record in the database. Then we can analyze the totality of the cases focusing on any variable entered into the record. The variables are comparable to the information requested on the yellow case reporting card. If you would be interested in having a specific report generated concerning data submitted by county and/or disease, please call Judith Gedrose at (406) 444-4740. Please remember the reports generated are only as good as the data entered -- if we have received a case card with no details, none will be present to be analyzed for the report. You're urged to include information for all case card sections such as race and sex as well as the disease and patient name.

MDHES' Communicable Disease Program has a complete computerized database for other than sexually transmitted diseases for 1986-1988. At the end of each year the databases are closed out but it is possible to add to a previous year's database if cases that should have been reported are subsequently discovered. Entry of cases is based on date of report but because one variable in the case record is onset, reports can be generated by onset. EPIINFO is available free of charge to all public agencies. If you have an IBM PC, contact MDHES regarding the program if you would be interested in using it.

SELECTED REPRINTS AND BIBLIOGRAPHIES RELATED TO IMMUNIZATION

The following is provided to MDHES from the Centers for Disease Control. Publications of articles about immunization activities and materials must not be interpreted as endorsement. If you would like a single copy of any of the following, contact the Montana Immunization Program office at 444-4740.

MEDICAL REPRINTS

Kaplan KM, Marder DC, Cochi SL, Preblud SR. Mumps in the workplace. JAMA 1988; 260:1434-8.

Markowitz LE, Chandler FW, Roldan EO, et al. Fatal measles pneumonia without rash in a child with AIDS. J Infect Dis 1988; 158:480-3.

Onorato IM, Markowitz LE, Oxtoby MJ. Childhood immunization, vaccine-preventable diseases and infection with human immunodeficiency virus. Pediatr Infect Dis 1988; 6:588-95.

Williams WW, Tudor JM. Immunizing adults: a challenge for family physicians. Med Times 1988; 116:43-5, 51-3.

SELECTED BIBLIOGRAPHIES

Measles - General

Sakata H, Sugiura A: Passive hemagglutination test for measles immunity and serodiagnosis. J Clin Microbiol 1988 Apr; 26(4):636-40.

Aaby P, Bukh J, Lisse IM da Silva MC: Further community studies on the role of overcrowding and intensive exposure on measles mortality. Rev Infect Dis 1988 Mar-Apr; 10(2):474-7.

Aaby P: Malnutrition and overcrowding/intensive exposure in severe measles infection: review of community studies. Rev Infect Dis 1988 Mar-Apr; 10(2):478-91.

Markowitz LE, Tomasi A, Hawkins CE, et al: International measles importations United States, 1980-1985. Int J Epidemiol 1988 Mar; 17(1):187-92.

Murray DL, Lynch MA: Determination of immune status to measles, rubella, and varicella-zoster viruses among medical students: assessment of historical information. Am J Public Health 1988 Jul; 78(7):836-8.

Whittle HC, Mann G, Eccles M, et al: Effects of dose and strain of vaccine on success of measles vaccination of infants aged 4-5 months. Lancet 1988 Apr 30; 1(8592):963-6.

Rubella

Fitzgerald MG, Pullen GR, Hosking CS: Low affinity antibody to rubella antigen in patients after rubella infection in utero. Pediatrics 1988 Jun; 81(6):812-4.

Morgan-Capner P, Thomas HI: Serological distinction between primary rubella and reinfection (letter). Lancet 1988 Jun 18; 1(8599):1397.

General Topics

Kafidi KT, Rotschafer JC: Bacterial vaccines for splenectomized patients. Drug Intell Clin Pharm 1988 Mar; 22(3):192-7.

Murray DL, Lynch MA: Determination of immune status to measles, rubella, and varicella-zoster viruses among medical students: assessment of historical information. Am J Public Health 1988 Jul; 78(7):836-8.

Roper J, Day S: Uptake of immunizations in low birthweight infants. Arch Dis Child 1988 May; 63(5):518-21.

Thomas P: Immunization of children infected with HIV: a public health perspective. Pediatr Ann 1988 May; 17(5):347-51.

Dyer C: Judge "not satisfied" that whooping cough vaccine causes permanent brain damage. Br Med J [Clin Res] 1988 Apr 23; 296(6630):1189-90.

Kendig EL Jr: Compensation for vaccine injury (editorial). Va Med 1988 Apr; 115(4):175.

IMMUNIZATION PROMOTION CAMPAIGNS

In April of each year, the Montana Immunization Program tries to promote immunization through an Immunization Action Month. The plan for this year is to focus on Hemophilus influenza type B disease and the new HIB conjugate vaccine. The Immunization Program will be developing promotional materials, i.e., news releases, radio advertising, etc. Start planning on how you, too, can help get a similar message out. Timing of this should be coordinated and areas that could be considered include: special clinics, talk shows, etc. There may be some special interest groups in your area that can also get involved.

In October we are planning an Adult Immunization Awareness Week and have received some promotional packages that can be used for that purpose. We will keep you up-to-date on the status of that activity. There is a session on adult immunization that is being planned for the Montana Public Health Association meeting in Bozeman during April.

Montana Immunization Manual

The first edition of the Montana Immunization Manual is being printed and will soon be distributed to public clinics and health departments. The manual will include the following under the Policy and Procedures section:

1. Vaccine supply (ordering, borrowing, storing, reporting, destroying and drug company information)

2. Record retention and management

3. Immunization clinic site considerations

4. Schedules, dosage administration

5. Vaccine/vaccine-preventable disease information, and

6. Adverse event following immunization.

Future additions to the manual will include sections on school/day care/college; surveillance and outbreak control and promotional materials. The manual is being made available to local health departments and public immunization clinics. The manual is intended for use in establishing policies and procedures for immunization clinics, primarily in the public sector, but may be of value to private clinics as well.

JANUARY 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead											1				
Big Horn		7		1	1		2							1	
Blaine		3													
Broadwater															
Carbon		1									1	1			
Carter															
Cascade		11		5			1					2			
Chouteau															
Custer		2										1			
Daniels															
Dawson	1	2		1											
Deer Lodge															
Fallon															
Fergus												1			
Flathead		1					1								
Gallatin		17	1								1				
Garfield															
Glacier		6		7										10	
Golden Valley															
Granite															
Hill			2			3	1								
Jefferson															
Judith Basin												1			
Lake		1					1							1	
Lewis & Clark		15	1				1								
Liberty															
Lincoln		3													
McCone															
Madison															
Meagher															
Mineral															
Missoula		13		1			1								
Musselshell												1			
Park		2													
Petroleum															
Phillips															
Pondera															
Powder River															
Powell															
Prairie															
Ravalli															
Richland															
Roosevelt		8		6											
Rosebud		1				1									
Sanders															
Sheridan															
Silver Bow		1					1								
Stillwater															
Sweet Grass															
Teton		1										1			
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		33		6			2						2		
MONTHLY TOTAL 1989	1	128	4	27	1	4	11	0	0	0	3	8	2	12	0
MONTHLY TOTAL 1988	2	224	4	32	1	5	6	1	2	0	12	17	3	12	0
MONTHLY TOTAL 1987	1	125	4	57	3	6	2	1	0	0	7	6	2	2	0
TOTAL TO DATE 1989	1	128	4	27	1	4	11	0	0	0	3	8	2	12	0
TOTAL TO DATE 1988	2	224	4	32	1	5	6	1	2	0	12	17	3	12	0
TOTAL TO DATE 1987	1	125	4	57	3	6	2	1	0	0	7	6	2	2	0

OTHER DISEASES: Chickenpox: Gallatin, 3; Lewis & Clark, 8; Meagher, 2; Yellowstone, 9; Cytomegaloviral Illness: Yellowstone, 1; Measles, Imported*: Flathead, 1; Measles, Indigenous*: Flathead, 12; Early latent Syphilis <1yr: Glacier, 1

*Onset for measles cases occurred in 1988, but were reported in January.

CURRENT STATISTICS

MONTANA AIDS CASES
Demographic Summary as of 1/15/89

CASES			SEX		
Reported Cases	25	100%	Female	3	12%
Reported Deaths	13	52%	Male	22	88%
				25	100%
AGE			RISK FACTOR		
Less than 5	0	0%	Homosexual/Bisexual Male	14	56%
5-12	0	0%	IV Drug Abuser	3	12%
13-19	0	0%	Homosexual Male & IVDA	2	8%
20-29	7	28%	Hemophilia, etc.	2	8%
30-39	13	52%	Heterosexual	3	12%
40-49	4	16%	Transfusion, Blood Components	0	0%
Over 49	1	4%	Undetermined*	1	4%
	25	100%		25	100%
RACIAL/ETHNIC GROUP			COUNTY OF DIAGNOSIS		
White	21	84%	Cascade	8	32%
American Indian	1	4%	Gallatin	1	4%
Black	1	4%	Lewis and Clark	2	8%
Hispanic	2	8%	Missoula	5	20%
Other/Unknown	0	0%	Silver Bow	1	4%
	25	100%	Yellowstone	5	20%
			Out-of-State Diagnosis	3	12%
				25	100%

Source: Montana AIDS Program, MDHES, January 15, 1989.

Note: There are nine (9) other AIDS cases which have been reported to MDHES. These were diagnosed and reported to Centers for Disease Control from other states. Those demographics are not included above.

As of January 31, 1989 there have been 177 positive HIV tests from 13,560 tests conducted through the DHES Public Health Laboratory.

* Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed, or loss to follow-up, and patients still under investigation).

Volume: 13:1 **Month of:** JANUARY, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

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Montana Morbidity Report

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Volume: 13:2 Month of: February, 1989

Montana State Department of Health and Environmental Sciences

Handicapped Children's Services

The Handicapped Children's Services Program (HCS) is a federally funded statewide program concerned with the early detection, diagnosis, treatment, rehabilitation and prevention of handicapping conditions in children to age 18. Recently the HCS Advisory Board met and broadened the prior list of eligible conditions to include children with conditions or diseases which can be cured, improved or stabilized with medical treatment, children with handicapping physical deformities that can be substantially improved or corrected surgically, and children whose condition, although handicapping, has a high likelihood of being correctable or great potential for return to a more functional state. Families can qualify for HCS funds which will be paid directly to providers by applying to the HCS Program, Cogswell Building, Helena, MT, or phoning 444-4740 to discuss the eligibility requirements. The HCS program hopes to assist those families for whom the cost of a chronic disease in childhood would be a great hardship. These families require services not covered by SSI, Medicaid or other types of comprehensive health insurance. The major exclusions from the program are children with behavioral, emotional, primary psychiatric disease and learning disabilities.

These new guidelines include children with a variety of chronic medical illnesses such as diabetes, asthma, arthritis, epilepsy, etc., in addition to children who have been traditionally served by the HCS program. We hope that all physicians will contact HCS about any child with a medically or physically handicapping condition who may be eligible for financial assistance. Unlike prior years, there is still money available for the rest of this fiscal year. HCS would like to hear from you about any and all of these children who may qualify for assistance.

PLEASE RETURN

DEPARTMENT OF
HEALTH AND ENVIRONMENTAL SCIENCES

STAN STEPHENS, GOVERNOR

COGSWELL BUILDING

STATE OF MONTANA

FAX # (406) 444-2606

HELENA, MONTANA 59620

March 1, 1989

HEALTH ADVISORY

Dear Doctor:

In June 1988, the U.S. Immunization Practices Advisory Committee (ACIP) recommended routine screening of pregnant women for Hepatitis B, in order to assure infants born to women who test positive for HBsAg would be offered prophylaxis against Hepatitis B in a timely manner. "All pregnant women should be routinely tested for HBsAg during an early prenatal visit in each pregnancy. This testing should be done at the same time that other routine prenatal screening tests are ordered. In special situations, such as when acute hepatitis is suspected, when there has been a history of exposure to hepatitis, or when the mother has a particularly high risk behavior such as intravenous drug abuse, an additional HBsAg test can be ordered later in the pregnancy." (Morbidity and Mortality Weekly Report, "Prevention of Perinatal Transmission of Hepatitis B Virus: Prenatal Screening of All Pregnant Women for Hepatitis B Surface Antigen," June 10, 1988/Vol. 37/No. 22, Centers for Disease Control.)

Reported cases of Hepatitis B in Montana have increased in the last 10 years. The average number of cases reported in the last four years has been 55 per year, compared to approximately 20 per year prior to 1985. It has been established in several studies regarding reporting that hepatitis of all types is seriously under-reported and the actual number of cases occurring in Montana may be 10 times as many as those reported. Hepatitis B is the second most commonly reported disease in the U.S. Therefore implementation of the ACIP recommendations in Montana is encouraged and we hope to facilitate it by offering HBsAg testing through the Montana Department of Health and Environmental Sciences' Public Health Laboratory. The fee for this testing is $1.75 per test. Payment is made by purchase of laboratory slips to be submitted with the specimen. These slips can be obtained by phoning 444-2642 or writing to the Department at the address on the letterhead. Questions may be directed to Douglas O. Abbott, Ph.D., Laboratory Director, at the above phone number and address.

Sincerely,

Sidney C. Pratt, M.D.
Interim Director

SCP/war-23xt

"AN EQUAL OPPORTUNITY EMPLOYER"

Announcing

COMMUNICABLE DISEASE INTERVIEWING/
FIELD INVESTIGATION COURSE
May 24-26, 1989
Billings, Montana

The above course, held in Helena in May of 1988, will be repeated in Billings, starting at 11:00 a.m. on May 24 and concluding at 11:00 a.m. on May 26. The course is intended for local public health agency professionals, but is open to others interested.

It will be submitted for CEARP through the Montana Nurses' Association. There will be no registration fee for the course. Those interested in attending are asked to send their name, address and agency affiliation to the Montana Department of Health and Environmental Sciences, Communicable Disease Section, Preventive Health Services Bureau, Cogswell Building, C-303, Helena, MT 59620 by May 1, 1989. Further information will be sent to the registrants about location, agenda, etc.

Following is an outline of the course with allotted hours:

Wednesday, May 24, 1989

Hours

1 - Statutes, Rules, Confidentiality
1 - Communicable Disease Theory
.5 - Public Health Lab Services
1.5 - When to Begin an Investigation, Case Management and Forms

Thursday, May 25, 1989

.5 - Communication
1.25 - Interview/Counseling Format
.5 - Cluster Interviewing
1 - Interview Video and Discussion
1.25 - Application of Interview Skills
1 - Application of Interview Skills (continued)
.75 - Principles of Field Investigation

Friday, May 26, 1989

.75 - Field Investigation (continued)
1.5 - Video and Application of Field Investigation Principles

12.5 hours

PPNG OUTBREAK IN BILLINGS

Two more cases of penicillinase-producing gonorrhea have been reported from Billings in late February. The source of this outbreak has yet to be identified, although one of the cases returned from out-of-state within 60 days of the report.

Physicians are asked to report gonorrhea isolates to their local health department, and ensure beta-lactamase testing. Physicians in the Billings area are asked to treat all gonorrhea patients with either spectinomycin or ceftriaxone, until it can be determined if PPNG has become endemic in the area.

STD CURRICULUM GUIDE AVAILABLE

The Montana STD Program reprinted and distributed 700 copies of the Instructor's Manual for STD: A Guide for Today's Young Adults, to principals of Montana's junior and senior high schools, in January 1989.

The 96-page Instructor's Manual includes the 40-page Student Manual. It was developed under a contract with the Centers for Disease Control in 1985, by Professor William Yarber of Indiana University.

Those interested in utilizing the manual may contact your local junior or senior high school, or write for a complimentary copy from the STD Program, MDHES, Cogswell Building, C-303, Helena, MT 59620 or call 444-4740.

A recent survey by the Office of Public Instruction indicated that 125/144 or 86.8% of Montana high schools are providing education about sexually transmitted diseases.

SURVEYS

The Montana Department of Health and Environmental Sciences has completed a survey of Montana's AIDS awareness. The survey was administered by the Department's AIDS Program during June, July and August 1988 and resulted in 396 complete interviews. Survey results will provide the Department with information to plan and evaluate AIDs intervention. The information will also be used to target groups for health promotion and risk reduction programs related to AIDS.

The survey asked those responding how much they know about AIDS and where they learned it; how they perceive persons affected with AIDS: whether AIDS prevention should be taught in Montana schools; and whether AIDS is a health problem which should be publicly funded.

Over 91% of those surveyed described themselves as very (28.0%) or somewhat (63.4%) knowledgeable about AIDS. Television was reported to be the resource where the majority of the respondents learned the most about AIDS.

The majority believed that persons with AIDS should be able to work or attend school. Even in jobs which involve public contact, such as banks and stores, 73.5% of those responding believe that a person with AIDS should be allowed to retain their job.

Nearly all respondents (95%) supported AIDS education being taught in the schools. More than 58% believe that education should begin at the elementary level.

With respect to safety of the blood supply, 61% of the respondents believed that it is safe to receive a blood transfusion from the Red Cross or similar blood bank, while 7% were unsure and 31% indicated that they did not think it safe.

Eighty-seven percent of those responding correctly identified the exchange of infected body fluids as the primary cause of the spread of AIDS. Most indicated that they thought the appropriate use of condoms would help control the spread of AIDS.

The Montana Department of Health and Environmental Sciences' AIDS Program is also conducting a year-long survey of IV drug users. The purposes of the survey are to determine the occurrence of behaviors which can spread the AIDS virus and to assess participants' knowledge of how AIDS is spread.

Two hundred thirty-three respondents have been included in the survey data to date. Most respondents were between 19 and 43 years of age, with the youngest being 14 and the oldest being 50. Seventy-eight percent reported their race as white; 15.5% were American Indian; the remaining 5.6% were Black, Hispanic or other. A large percentage of respondents (72%) report having shared needles to inject drugs. Eighty-eight percent report that they have not donated blood since they started injecting drugs. Most of the respondents (69.4%) do not use condoms when engaging in sex. Fifty-five percent of those responding do not consider themselves at risk for being exposed to AIDS.

MDHES has funded five other surveys which are now under way and results will be published when complete. Those surveys include one of school administrators, one of clients at family planning clinics, one of gay/bisexual males, another of teachers, and a final one of health care providers.

Serosurvey of Child-bearing Women

Montana and 43 other states are included in a study funded by the Centers for Disease Control (CDC) which will test neonate blood to determine HIV antibody status of Montana mothers giving birth in 1989. Mothers of any babies who test positive for the antibody to the AIDS virus will not be notified since their will be no names attached to the samples tested. The state already tests babies' blood for diseases at birth and no extra blood will be needed to conduct this survey.

CURRENT STATISTICS

MONTANA AIDS CASES
Demographic Summary as of 2/15/89

CASES			SEX		
Reported Cases	27	100%	Female	3	11%
Reported Deaths	14	52%	Male	24	89%
				27	100%
AGE					
Less than 5	0	0%	RISK FACTOR		
5-12	0	0%	Homosexual/Bisexual Male	16	59%
13-19	0	0%	IV Drug User (IVDU)	3	11%
20-29	7	26%	Homo/Bisexual Male & IVDU	2	7%
30-39	14	52%	Hemophilia, etc.	2	7%
40-49	4	15%	Heterosexual	3	11%
Over 49	2	7%	Transfusion, blood components	0	0%
	27	100%	Undetermined *	1	4%
				27	100%
RACIAL/ETHNIC GROUP					
White	23	85%	COUNTY OF DIAGNOSIS		
American Indian	1	4%	Cascade	7	26%
Black	1	4%	Gallatin	1	4%
Hispanic	2	7%	Lewis and Clark	3	11%
Other/Unknown	0	0%	Missoula	6	22%
	27	100%	Silver Bow	1	4%
			Yellowstone	6	22%
			Out-of-State Diagnosis	3	11%
				27	100%

Source: Montana AIDS Program, MDHES, February 15, 1989.

NOTE: There are ten (10) other AIDS cases which have been reported to Montana DHES. These were diagnosed and reported to Centers for Disease Control from other states. Those demographics are not included above.

* Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed, or loss to follow-up, and patients still under investigation).

Statistics

Statistics for HIV tests and AIDS cases will be available through the Montana AIDS Hotline beginning March 10, 1989. Montana statistics as well as national statistics can be obtained by calling the toll-free Hotline number: 800-233-MONT (6668).

Program: AIDS: A Montana Perspective

Target Audience: Educators, clergy, medical workers, social workers, etc.

Dates: Friday, April 21, 1989; 9:00 a.m. to 5:00 p.m.

Location: Strand Union Building
Montana State University
Bozeman, MT 59717

Sponsor: Montana Academy of Sciences

Contact: Patricia Crowle, Meeting Coordinator or Carol Buchheit, Secretary

Address: 2-208 Wilson Hall
Montana State University
Bozeman, MT 59717

Phone: (406) 994-5023

Credit: N/A

Fee: $10.00 pre-registration
$20.00 on-site registration

FEBRUARY 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1													
Big Horn		1		1										4	
Blaine		1													
Broadwater															
Carbon												1	1		
Carter															
Cascade		15		2		1							1		
Chouteau															
Custer		1													
Daniels															
Dawson		2													
Deer Lodge		1													
Fallon															
Fergus															
Flathead															
Gallatin		27		1				1			1		1		
Garfield															
Glacier		3		1										15	
Golden Valley															
Granite															
Hill		5											1		
Jefferson															
Judith Basin												1			
Lake															
Lewis & Clark		13	1	1											
Liberty															
Lincoln		2													
McCone															
Madison															
Meagher															
Mineral															
Missoula	1	12	4	4			1						1		
Musselshell			1								3	1			
Park		2													
Petroleum															
Phillips													1		
Pondera															
Powder River															
Powell		1		1											
Prairie															
Ravalli		2													
Richland															
Roosevelt		3	1	3									1	1	
Rosebud	1	1				1					1			1	
Sanders															
Sheridan															
Silver Bow	2	7	3	3		1									
Stillwater															
Sweet Grass															
Teton															
Toole												1			
Treasure															
Valley	2														
Wheatland											2				
Wibaux															
Yellowstone		20	1	3		1							3	2	
MONTHLY TOTAL 1989	6	120	11	18	0	4	1	1	0	0	7	4	12	23	0
MONTHLY TOTAL 1988	3	176	29	37	2	9	4	0	0	0	4	17	5	0	0
MONTHLY TOTAL 1987	0	88	12	54	2	2	4	1	0	0	3	10	3	4	2
TOTAL TO DATE 1989	7	248	15	45	1	8	12	1	0	0	10	12	14	35	0
TOTAL TO DATE 1988	5	400	33	69	3	14	10	1	2	0	16	34	8	12	0
TOTAL TO DATE 1987	1	213	16	111	5	8	6	2	0	0	10	16	5	6	2

OTHER DISEASES:

Chickenpox: Cascade, 7; Gallatin, 4; Madison, 21; Yellowstone, 67
Bacterial Meningitis Unspecified: Jefferson, 1
Leprosy: Yellowstone, 1

AAP Drops Fever Per Se as Contraindication to MMR and OPV

The Montana Immunization Program recommends that public immunization clinics operate under the general guideline of the ACIP, which is as follows: "Minor illnesses, such as mild upper-respiratory infections, should not postpone vaccine administration. However, immunization of persons with severe febrile illnesses generally should be deferred until they have recovered," (MMWR 32:1-17, Jan. 14, 1983). This guideline leaves the situation of a mild febrile illness somewhat in limbo.

In the latest edition of the Red Book (American Academy of Pediatrics: Report of the Committee on Infectious Diseases, Twenty-First Edition, 1988, page 21) the AAP presents what the Immunization Program believes is a useful refinement of this guideline. That is, the AAP now recommends that a minor illness with fever is not a contraindication to live virus vaccines (MMR, OPV) but is a contraindication to DTP and other vaccines. Here is the AAP's recommendation verbatim:

1. **Live viral vaccines.** Minor illnesses with or without fever should not contraindicate the use of live viral vaccines. Such intercurrent illnesses are not known to interfere with the immune response to the vaccines, and no evidence indicates an increased risk from vaccination. Deferring immunization of children in such circumstances frequently results in failure to immunize young children at the desired age.

   Although fever per se is not a contraindication to immunizations, if it is associated with other manifestations suggesting a more serious illness, the child should not be vaccinated until recovery.

2. **DTP and other vaccines.** A febrile illness is a contraindication to administering DTP, as the vaccine may be blamed for the signs and symptoms associated with the illness. Although the illness may be trivial, it also might the harbinger of a more serious disease for which the vaccine might be blamed.

The 1988 AAP Redbook Now Available

The latest edition of the Academy's Redbook is now available and contains expanded information for private physician reporting of adverse events following immunization. Although AAP's Redbook committee continues to recommend the toddler doses of polio and DTP be given at 18 months, the Committee suggests "Since the Haemophilus conjugate vaccine... is now also recommended at 18 months of age, physicians may wish to choose the option of giving DTP at 15 months concomitantly with MMR and at 18 months give only PRP-D," e.g., Hib-conjugate.

To obtain a copy and information on quantity prices, write to:

The American Academy of Pediatrics
141 Northwest Point Boulevard
P. O. Box 927
Elk Grove Village, IL 60007

Attitudes of Seniors Toward Pneumococcal and Influenza Immunization

Results of a recent survey of senior citizens in Georgia on this subject were published in MMWR (Vol. 37, pp. 657-661, Nov. 4, 1988). The study was done as part of an effort to find out why only 20% of seniors take influenza vaccine annually and only 10% have received pneumococcal vaccine. Principal findings:

1. Large proportions of the seniors that knew about pneumococcal or influenza vaccines had negative attitudes about their necessity, efficacy, and/or safety. Such attitudes decreased vaccine usage by 20-30%.

2. The most potent factor influencing usage of these vaccines by seniors was the recommendation of their physician. A positive recommendation by a senior's physician increased his/her acceptance (uptake) of the vaccines 11 to 12-fold.

The investigators concluded that health care providers, particularly physicians, can greatly increase the usage of pneumo-

coccal and influenza vaccines by their older patients by:

1. Informing them of the efficacy, safety, and availability of these vaccines;

2. Recommending that they take the vaccines; and

3. Routinely offering the vaccines in their offices/clinics and at the time of hospital discharge.

New Hib Vaccine Licensed

Another "second generation" conjugate Hib vaccine has been licensed. The new vaccine, manufactured by Praxis Biologics, is a conjugate of the Haemophilus influenzae type b bacteria coating polyribose phosphate with a diphtheria toxoid. Because the diphtheria toxoid for the new vaccine is different from the one used in Connaught's conjugate vaccine, the new vaccine is being nicknamed PRP-OC while Connaught's is referred to as PRP-D. The PRP-OC is licensed as a single dose vaccine for children ages 18 months through 4 years, as in Connaught's PRP-D vaccine, and also like the latter, cannot be used to confer immunity against diphtheria.

It is anticipated that the protective efficacy of the new vaccine will be at least comparable to that of Connaught's PRP-D conjugate vaccine. The Immunization Program will continue to provide one or the other of these Hib conjugate vaccines to public clinics.

Although the new 1988 Redbook refers to Haemophilus influenzae type B vaccine as PRP-D, we recommend the name "Hib conjugate" (rather than these initials) continue to be used, along with manufacturer and lot number, or provider records.

Volume: 13:2 **Month of:** February, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

Distributed without charge to health care providers at a cost of 6¢ per copy for printing and 7¢ per copy mailing.

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Montana Morbidity Report

VOLUME: 13:3

Month of: MARCH, 1989

Montana State Department of Health and Environmental Sciences

Meningococcal Meningitis

There have been recent reports in the media concerning an outbreak of meningococcal meningitis in Washington State. Conversations with Washington State Health Department on Friday, March 31st revealed the following information. Cases of meningococcal meningitis began occurring in mid-January 1989 in the Yakima area. There have been 18 cases of meningitis and/or meningocemia with six deaths occurring. Thirteen of the 18 cases have been in pre-schoolers and the oldest case has been 23 years of age. The last two cases had onset on March 10th and March 23rd, respectively. Therefore, the Department feels the outbreak is subsiding. The organism is group C, resistant to sulfa, but sensitive to rifampin. All but two of the cases have been Hispanic and/or Native American. There has been a vaccination campaign carried out in Wapato, White Swan, Toppenish and Harra. A total of 10-15,000 residents have been vaccinated.

Washington State Department of Health recommends usual activities be carried out at this time. There should be no reason to restrict travel to the area or any other normal activities related with the area.

TICKS

It's time to begin issuing warnings via the media concerning ticks. Ticks are blood-sucking arachnids, capable of transmitting serious and sometimes fatal illness. Late spring and summer are the peak times for exposure to ticks in Montana. The diseases transmitted by ticks include Colorado Tick Fever, Rocky Mountain Spotted Fever and tularemia. There is no evidence that ticks in Montana transmit Lyme Disease. The best protection from tick-borne diseases is prevention and persons can be encouraged to do the following:

-- Avoid tick infested areas.

-- Apply repellant such as diethltholuamide (DEET) to clothing.

-- Wear clothing that interferes with tick attachment; long sleeves, high boots, sleeves that are tight around the wrist, pant legs which are gathered around the ankle.

-- After being in areas where ticks may attach, a person should check for ticks at least every four hours. Ticks not allowed to attach to a person will not transmit disease.

-- Ticks should be removed in a manner which removes the entire tick but does not crush them or allow the secretions from the tick to contaminate the person removing them.

MARCH 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead				1											
Big Horn				2										3	
Blaine															
Broadwater															
Carbon															
Carter															
Cascade			2	3							1	2			1
Chouteau															
Custer															
Daniels												1			
Dawson															
Deer Lodge															
Fallon											1				
Fergus			1												
Flathead							2								1
Gallatin			1										1		
Garfield															
Glacier				2									1	9	
Golden Valley															
Granite															
Hill			1										1		
Jefferson															
Judith Basin															
Lake				1		1									
Lewis & Clark				2							1				
Liberty															
Lincoln															
McCone															
Madison										1					
Meagher															
Mineral															
Missoula			1												
Musselshell															
Park			1												
Petroleum															
Phillips															
Pondera											1	1			
Powder River															
Powell															
Prairie															
Ravalli				1											
Richland															
Roosevelt														1	2
Rosebud			1												
Sanders						1									
Sheridan															
Silver Bow						1							1		
Stillwater															
Sweet Grass															
Teton												1			
Toole											1				
Treasure															
Valley												1			
Wheatland												2			
Wibaux															
Yellowstone				1		1	1						1		
MONTHLY TOTAL 19 89	0	*	9	13	0	4	3	0	0	1	5	8	5	13	4
MONTHLY TOTAL 19 88	2	168	11	37	1	2	5	2	0	0	3	29	5	3	0
MONTHLY TOTAL 19 87	0	104	17	27	2	6	4	3	1	0	10	13	3	3	3
TOTAL TO DATE 19 89	7	*	24	58	1	12	15	1	0	1	15	20	19	48	4
TOTAL TO DATE 19 88	7	568	44	106	4	16	15	3	2	0	19	63	13	15	0
TOTAL TO DATE 19 87	1	317	33	138	7	14	10	5	1	0	15	43	9	11	8

OTHER DISEASES: Chickenpox: Cascade, 1; Hill, 17; Madison, 6; Park, 8; Silver Bow, 1; Yellowstone, 74; Legionellosis: Cascade, 1; Gallatin, 1; Mumps: Gallatin, 1; Rubella: Missoula, 1; Syphilis, Late Latent: Musselshell, 1; Syphilis, Early Latent <1 yr: Cascade, 1

* Chlamydia numbers unavailable for March, 1989.

TREATMENT AND RESEARCH

Ganciclovir Status Update

FDA will convene its Anti-Infective Drugs Advisory Committee on May 2, 1989, in order to evaluate new evidence regarding ganciclovir -- an experimental therapy for AIDS patients with cytomegalovirus (CMV) retinitis, an eye infection that can lead to blindness. In the meantime, recognizing the need for patients to have access to this drug, the agency, the drug's manufacturer and the National Institute of Allergy and Infectious Diseases are also taking steps to make the drug more readily available to AIDS patients at earlier stages of CMV retinitis.

In November 1988, FDA approved a series of new protocols submitted by the drug's manufacturer Syntex Corp. of Palo Alto, California, and the National Institute of Allergy and Infectious Diseases (NIAID) that were designed to more fully evaluate the drug while also providing widespread access to those patients most likely to benefit from its use. These protocols were developed by the company and NIAID in response to the October 1987 recommendation of FDA's Anti-Infective Drugs Advisory Committee, which cited the need for additional safety and efficacy data and recommended that well designed, prospective controlled clinical studies be conducted.

Under this group of protocols, patients with immediately sight-threatening CMV retinitis, who make up the vast majority of AIDS patients with this condition, have been eligible under a treatment IND to receive immediate access to ganciclovir treatment if necessary, with very close monitoring for disease progression.

Since the advent of these new protocols, several scientific sources have indicated that they have developed, or are soon likely to develop, new data on ganciclovir that might answer many of the questions about the drug's use for this indication. To review these data in the most timely and effective manner, FDA has requested that this evidence be presented before its Anti-Infective Drugs Advisory Committee--a panel of outside medical experts who advise the agency on complex regulatory and scientific questions.

Although the committee's recommendations are not binding upon the agency, they are given a great deal of consideration by the agency in developing its policies and action. Prompt review and evaluation of all newly available data on ganciclovir by the committee during its May 2 hearing would, in turn, help the agency to take any appropriate action quickly.

In the meantime, the agency is also working with the company and NIAID, to ensure that patients at any stage of CMV retinitis have access to the drug. For this reason, AIDS patients with non-immediately sight-threatening CMV retinitis who cannot be enrolled in the controlled study will now have access to the drug through an open use protocol. Physicians enrolling their patient in this study will be asked to carefully monitor and report their patient's status to the sponsor on a regular basis.

Physicians who have patients that they feel may be eligible for this or the other on-going ganciclovir protocols are encouraged to call the Ganciclovir Study Center at (301) 497-9888.

Aerosolized Pentamidine

The Food and Drug Administration granted permission for the expanded distribution of an experimental, aerosolized version of the drug pentamidine to help prevent Pneumocystis carinii pneumonia, a potentially life-threatening infection that often afflicts AIDS patients.

Under the conditions of the FDA-approved protocol, the drug will be recommended for use in AIDS virus-infected individuals who have had at least one episode of the pneumonia or who have T4 helper cell counts of 200 per cubic millimeter or less. T4 helper cells are white blood cells that are critical components of the

body's immune system which are destroyed by the AIDS virus. Healthy individuals normally have T4 helper cell counts of 1,000 or more.

The drug should be administered to patients through the Respirgard II nebulizer and at a recommended effective dosage of 300 milligrams for every four weeks, based on recently available clinical data from the comparative dose trial conducted by the San Francisco Community Consortium, a group of physicians with experience treating people with AIDS. In this study, headed by Bruce Montgomery, M.D., David W. Feigel, M.D., M.P.H., and Gifford Leoung, M.D., individuals infected with the AIDS virus who were at high risk of developing the pneumonia had a lower incidence of infection when treated with this dose than similar patients treated with lower doses. This regimen is different from that used by many physicians who have tried this therapy on individual patients. This is the first treatment IND emanating from a clinical trial sponsored jointly by a community research initiative and a pharmaceutical company.

FDA's announcement will make the aerosolized product available under the agency's "treatment IND" regulations -- a plan for the use of an investigational new drug (IND) in selected patients facing serious or life-threatening conditions.

The clinical study compared the safety and efficacy of aerosolized pentamidine at 30 mg every two weeks, 150 mg every two weeks, or 300 mg every four weeks, and showed effective results with the last regimen. This did not provide complete protection, but did demonstrate the ability to significantly reduce the incidence of this pneumonia.

A large, long-term epidemiologic study undertaken by NIAID showed that a significant percentage of persons who have been infected with the AIDS virus and who have T4 helper cell counts of 200 or less are at risk of developing Pneumocystis carinii pneumonia even if they have no symptoms of HIV infection. Aerosolized pentamidine can provoke severe wheezing and coughing. The long term risks associated with aerosolized pentamidine are unknown.

LyphoMed Inc of Rosemont, IL, which markets pentamidine, partially underwrote the San Francisco Community Consortium study and will sponsor the treatment IND protocol. The company has also filed a new drug application with FDA seeking marketing approval for this version of the drug. Aerosolized pentamidine is the third AIDS-related therapy to have received "treatment IND" status under new FDA regulations.

Physicians interested in learning about the details of this protocol can contact a hotline set up by the company at 1-800-PCP-7003.

The Respirgard II nebulizer, a filtering system used in the studies, is manufactured by the Marquest Corp. of Englewood, CO.

Skin and AIDS

Abstract: "Skin Signs in AIDS: Textbook of AIDS/HIV Infection-Related Dermatology," by Kaare Weismann and colleagues, is a high quality and useful reference book for any medical practitioner who treats HIV-infected patients, writes reviewer Keymoumars Soltani. Dermatological manifestations are high on the list of the numerous specific and secondary symptoms of HIV infection, but many physicians may overlook some of the more subtle cutaneous changes associated with the disease. The book provides background on AIDS, ARC, and HIV infection, as well as an atlas of cutaneous findings in AIDS and ARC patients. The chapters on the various types of lesions have numerous high quality close-up photographs and some photomicrographs. For non-dermatologists, the photos and descriptions have great teaching value.

(Soltani and Keymoumars, Journal of the American Medical Association (02/24/89), Vol. 261, No. 8, P. 1209.)

Mixing Alpha-Interferon and AZT May Cause Toxicity

Abstract: Hoffman-LaRoche, the maker of alpha-interferon, has warned physicians that the drug may produce synergistic toxicity if used together with AZT in people with AIDS. Although several studies of the two are underway, a spokeswoman for the company said, ". . . alpha-interferon is not indicated for use in combination with zidovudine (AZT)." The drug, which received Food and Drug Administration approval in December 1988 for the treatment of AIDS-related Kaposi's sarcoma, should also not be used in several other cases, including patients with cardiac disease. Patients with compromised central nervous system functions have also had adverse reactions with the drug. Susan E. Krown, a researcher at Memorial Sloan-Kettering Cancer Center in New York, says the ideal candidates for KS treatment with alpha-interferon are 18 years old or older; do not have fever, weight loss, night sweats, or other systemic systems; have no prior history of opportunistic infection; and have CD4--T4 helper -- cell counts above 200 and a relatively intact immune system.

(AIDS Alert (02/89), Vol. 4, No. 2, P. 28.)

TRENDS

Counseling High-Risk Youth

Counselors who work with high-risk adolescents should not develop unreal expectations, warns Ken Dunnigan, medical director of Larkin Street Youth Center and district health officer at Health Center Number One in San Francisco. Counselors face a challenge when attempting to facilitate changes in high-risk behaviors such as experimentation with drugs and sex. Youth who are homeless, runaways, IV drug users, abused, out of school, gay or lesbian, or incarcerated are among those at greatest risk. The aim of counseling is to reduce unsafe sex and needle sharing, and the substance use that can lead to unsafe behaviors. The counselor should present HIV information as part of a relationship with the client that emphasizes personal empowerment, not social control. Counselors must assess a youth's cognitive stage and gain an understanding of why adolescents engage in high risk behavior. Group sessions may enhance the counseling experience. Counselors must be aware of their own values and prejudices regarding the clients and how they behave.

(Focus: A Guide to AIDS Research (03/89), Vol. 4, No. 4, P. 3.)

Hold the Hugs

In an editorial called "Trading in Teddy," in the Winter 1989 issue of the PWA Voice, a San Francisco journal for people with AIDS (PWAs), editor Andre Laventure writes that people ill with AIDS often need practical assistance. "Hand-patting is easy to come by, but real concrete assistance is hard to find. The next time you visit your PWA, make a casserole or a pot of soup. Vacuum once a week or do a load of wash. Make a trip to the cleaners or the post office for your friend. Above all, ask the PWA what you can do to be useful and really listen to what is needed." Noting that practical help means more than a teddy bear, Laventure concludes, "I feel better when my house is tidy, I've brushed my hair, and my bills are paid; I'm most comforted by those who help me uncomplicate my life."

(Helquist, Michael, Advocate (03/14/89), P. 24.)

What Laboratory Tests Are Available for HIV?

Tests to detect antibodies to HIV have been licensed and are commercially available routinely in the United States. These tests can be expected to identify most persons with HIV infection. The tests are NOT tests for AIDS. They only detect the presence of antibody against the HIV virus.

The HIV antibody tests consist of screening tests for initial testing of specimens, and supplemental tests to verify the screening results. Positive initial screening tests are repeated in duplicate to increase the accuracy of the test result and those specimens which are repeatedly reactive are tested with supplemental or confirmatory tests. Only those specimens which are repeatedly reactive by screening tests, and confirmed by a supplemental test are considered to be positive for the presence of antibody to HIV.

A variety of other tests related to HIV testing, such as HIV culture and HIV antigen testing, are also available in the United States. These tests may be used in special circumstances and in following HIV antibody positive patients for disease progression. Tests are being developed and improved constantly. The status of these tests and their availability can be obtained through consultation with the Public Health Laboratory, Montana Department of Health and Environmental Sciences (444-2642).

AIDS Drug Reimbursement Program

The Montana Department of Health and Environmental Sciences provides AZT for qualified persons as a component of its AIDS/STD Program. The MDHES received initial funding for the AIDS Drug Reimbursement Program (ADRP) from the Health Resources Services Administration. This agency is a subdivision of the U.S. Department of Health and Human Services. The initial ADRP funds were available in the fall of 1987 and were designated for the purchase of AZT (zidovudine or Retrovir). Additional funds were received in the fall of 1988 and again the only drug therapy authorized for payment under these funds was AZT.

The ADRP was in place several months before the first eligible applicant was registered. An eligible applicant is a person who is at least HIV positive, has physician verification that AZT therapy would be beneficial, does not have third party payment to cover the cost of AZT (i.e., does not qualify for Medicaid nor have private insurance that will cover 100% of the cost of AZT), and can show that self-purchase of the drug would cause a severe economic imbalance on the family unit. Since the first person enrolled in ADRP, the program has served up to 9 people at a time. Currently, there are 3 people enrolled in the program.

The application process is straightforward. A person may simply contact the MDHES AIDS/STD Program or the local counseling and testing site to request an application. The application consists of several pages of information that includes personal identifiers, financial information, consent forms, and a physician authorization statement. The AIDS/STD program attempts to place a person in ADRP quickly so the person can begin receiving AZT by the first month immediately following the month of application. The applicant must verify within 60 days that they do not qualify for Medicaid. This confidential verification continues as long as the person remains in ADRP. Should the person eventually qualify for Medicaid and its additional benefits, the person is no longer eligible for ADRP services.

The MDHES will continue the ADRP in its present form as long as funding is available. At the present rate of consumption, the funds should last until November 1989. Some of the persons enrolled in ADRP have third party insurance that covers 80% of the monthly cost of AZT. With the cost of the drug at just over $725 per month, the shared cost of the drug with co-payers serves to extend the life of the program. The drug is provided to eligible persons directly from pharmacies with which the MDHES has established cooperative agreements. The person need only present the monthly certification form provided by the AIDS/STD Program to the pharmacy. The pharmacy will dispense the drug at that time and charge the cost of the AZT to the AIDS/STD Program's AIDS Drug Reimbursement Program.

For more information about ADRP, contact the MDHES AIDS/STD Program (Rick Chiotti 444-4740), your local counseling and testing site, the AIDS support network nearest you, or OIM.

CURRENT STATISTICS

*MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 03/15/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	19 (49)	6 (32)
Other Disease w/o PCP	19 (49)	12 (63)
KS Alone	1 (3)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	39 (100)	18 (46)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	12 (31)
30-39	18 (46)
40-49	7 (18)
Over 49	2 (5)
Unknown	0 (0)
Total	39 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	35 (90)
Black, Not Hispanic	1 (3)
Hispanic	2 (5)
Other	1 (3)
Unknown	0 (0)
Total	39 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	23 (64)	0 (0)	23 (59)
Intravenous (IV) Drug User	4 (11)	0 (0)	4 (10)
Homo/Bi IV Drug User	4 (11)	0 (0)	4 (10)
Hemophiliac	2 (6)	0 (0)	2 (5)
Heterosexual Contact	0 (0)	3 (100)	3 (8)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (8)	0 (0)	3 (8)
Total	36 (100)	3 (100)	39 (100)

Source: Montana AIDS Program, MDHES, March 15, 1989

*Includes 27 Montana AIDS cases and 12 cases reported to Centers for Disease Control from other states who are living in Montana.

As of March 31, 1989 there have been 189 positive HIV tests from 14,406 tests conducted through the MDHES Public Health Laboratory.

RESOURCES

Native American Information

The National Native American AIDS Prevention Center has a Native American AIDS 101 presentation with transparencies, slides, a workbook, and a video addressing Native American AIDS issues. It stresses tribal community involvement and the importance of Community Health Representatives. There is a narration built into the illustrations that can be blanked out if you would like to provide your own information. It is available for $21.00 per set from: National Native American AIDS Prevention Center, 6239 College Avenue, Suite 201, Oakland, CA 94618.

Students Teaching AIDS to Students

STATS: Students Teaching AIDS to Students, by Grant Haven and Jeffrey Stolz, is the American Medical Students Association manual for medical students who are teaching adolescents about AIDS. STATS includes a guide to the curriculum, pre- and post-tests, games and exercises, slides for presentations to school boards and parent groups, and information on creating a speakers bureau. The educational games and exercises encourage students to explore the social issues involved in AIDS. STATS, which is designed for two hour-long class periods, has the flexibility to allow instructors to make the curriculum age-appropriate and sensitive to community standards.

(Focus: A Guide to AIDS Research (03/89), Vol. 4, No. 4, P. 4.)

Selected Bibliographies and Reprints Related to Immunization

The following is provided to MDHES from the Centers for Disease Control. Publications of articles about immunization must not be interpreted as endorsement. If you would like a single copy of any of the following, contact the Montana Immunization Program office at 444-4740.

MEASLES

Moench TR, Griffin DE, Obriecht CR, et al: Acute measles in patients with and without neurological involvement: distribution of measles virus antigen and RNA. J Infect Dis 1988 Aug; 158(2):433-42.

RUBELLA

Sawinska B: Infection of the mother with the rubella virus in pregnancy (Polish). Pieleg Polozna 1988; (3):10-1.

De la Mata I, De Wals P: Policies for immunization against rubella in European countries. Eur J Epidemiol 1988 Jun; 4(2):175-180.

Kotzen II, Mets JT: Rubella sensitivity in young women -- an occupational hazard in hospitals. S Afr Med J 1988 Jul 16; 74(2):62-5.

MUMPS

Kaplan KM, Marder DC, Cochi SL, Preblud SR: Mumps in the workplace. Further evidence of the changing epidemiology of a childhood vaccine-preventable disease. JAMA 1988 Sep 9; 260(10):1434-8.

DIPHTHERIA-PERTUSSIS-TETANUS

Kjeldsen K, Simonsen O, Heron I: Immunity against diphtheria and tetanus in the age group 30-70 years. Scand J Infect Dis 1988; 20(2):177-85.

Haemophilus influenzae Infections

Smith, PF, Stricof RL, Shayegani M, Morse DL: Cluster of Haemophilus influenzae type b infections in adults. JAMA 1988 Sep 9; 260(10):1446-9.

Harrison LH, Broome VC, Hightower AW, et al: A day care-based study of the efficacy of Haemophilus b polysaccharide vaccine. JAMA 1988 Sep 9; 260(10):1413-8.

Osterholm MT, Rambeck JH, White KE, et al: Lack of efficacy of Haemophilus b polysaccharide vaccine in Minnesota. JAMA 1988 Sep 9; 260(10):1423-8.

Shapiro ED, Murphy TV, Wald ER, Brady CA: The protective efficacy of Haemophilus b polysaccharide vaccine. JAMA 1988 Sep 9; 260(10):1419-22.

VARICELLA-ZOSTER INFECTIONS

Balfour HH Jr: Varicella zoster virus infections in immunocompromised hosts. A review of the natural history and management (review). Am J Med 1988 Aug 29; 85(2A):68-73.

Feldman S: Varicella zoster infections of the fetus, neonate, and immunocompromised child (review). Adv Pediatr Infect Dis 1986; 1:99-115.

Bergink GJ, Gill K: Minor symptoms in family practice; herpes zoster (Dutch). Ned Tijdschr Geneeskd 1988 Jul 2; 132(27): 1237-7.

Kangro HO, Ward A, Argent S, et al: Detection of specific IgM in varicella and herpes zoster by antibody-capture radioimmunoassay. Epidemiol Infect 1988 Aug; 101(1):187-95.

Kirk JA, Menser MA, Bergin M, et al: Varicella-zoster virus infection in a pediatric oncology unit. Pediatr Infect Dis J 1988 Jul; 7(7):520-2.

CHOLERA

Clemens JD, Sack DA, Harris, JR, et al: Cross-protection by B subunit-whole cell cholera vaccine against diarrhea associated with heat-labile toxin-producing enterotoxigenic Escherichia coli: results of a large-scale field trial. J Infect Dis 1988 Aug; 158(2):372-7.

Levine MM, Kaper JB, Herrington D, et al: Safety, immunogenicity and efficacy of recombinant live oral cholera vaccines, CVD 103 and CVD 103-HgR. Lancet 1988 Aug 27; 2(8609):467-70.

IMMUNIZATION - GENERAL

Eskola J, Kayhty H, Gordon LK, et al: Simultaneous administration of Haemophilus influenzae type b capsular polysaccharide-diphtheria toxoid conjugate vaccine with routine diphtheria-tetanus-pertussis and inactivated poliovirus vaccinations of childhood. Pediatr Infect Dis J 1988 Jul; 7(7):480-4.

DPT Immunization Does Not Increase the Risk of SIDS

Sudden infant death syndrome (SIDS) strikes infants without warning, leaving in its wake anguished parents looking for explanations. There has been considerable concern that immunization against diphtheria, pertussis, and tetanus (DPT) may increase the risk of SIDS. However, a new study sponsored by the National Center for Health Services Research and Health Care Technology Assessment (NCHSR) under grant HS05179 found no increased risk of SIDS in children immunized at least once against DPT during the first year of life. The researchers used the computerized immunization records of public health clinics in four Tennessee counties and linked them to State vital statistics and Medicaid records. The study group consisted of nearly 130,000 children born from 1974 through 1984 who received DPT immunizations from public health clinics or Medicaid providers. The children represented 42 percent of the births in these counties during the period.

The researchers also found that the risk of SIDS was lowest during the first week following immunization. According to Vanderbilt University's Marie R. Griffin, M.D., Wayne A. Ray, Ph.D., and William Schaffner, M.D., as well as John R. Livengood, M.D., of the Centers for Disease Control, the most plausible explanation is that children may be immunized when they are in better health and a healthy state may diminish the risk of SIDS. The findings are similar to the results of a large study by the National Institute for Child Health and Human Development. Together, say the researchers, the studies provide strong evidence that DPT immunization does not raise the risk of SIDS in infants. U.S. Public Health Service agencies cooperating in the new study were the Centers for Disease Control and the Food and Drug Administration. Details are in the September 8, 1988, New England Journal of Medicine.

The analysis was conducted as part of a recently completed NCHSR-funded (grant HS05424) research project led by Dr. Ray that tested the feasibility of using large Medicaid data bases in postmarketing surveillance of prescription drugs. The methodology used in developing and testing the project's data base will be described in a forthcoming issue of the American Journal of Epidemiology.

From: National Center for Health Services Research and Health Care Technology Assessment Bulletin, January 1989, No. 113.

Montana Gonorrhea Morbidity

Gonorrhea morbidity in Montana continues to decline with a 32.3% decline in Calendar year 1988 from the 619 cases reported in 1987. This represents an incidence rate of 51 cases per 100,000 population, well below the national gonorrhea rate of 292 cases per 100,000 population. Gonorrhea continues to be the number one reportable communicable disease in the United States, even though in Montana, 1,958 cases of chlamydia genital infections were reported in 1988 compared to 421 gonorrhea infections.

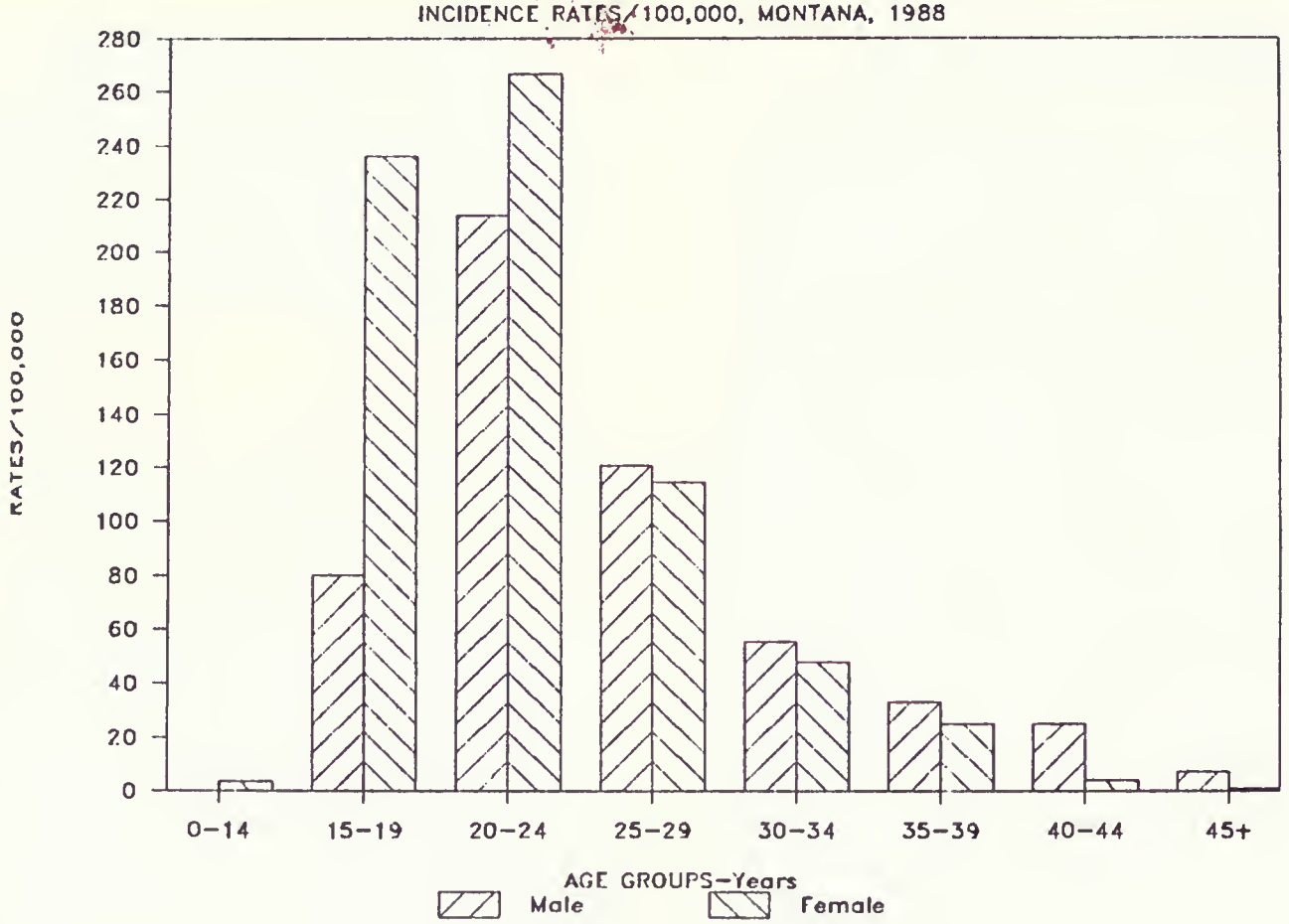
The figure below illustrates the age/sex specific incidence rates for gonorrhea in Montana for 1988. The female incidence rate for gonorrhea exceeds that for males in Montana, contrary to the national sex specific incidence rates. A significant difference can be noted in the 15 to 19 year age group, where the female incidence rate is three times that of the male rate. The age/sex specific rates for genital chlamydia infections in Montana shows a similarly high incidence in the 15 to 24 age group for females.

By October 1, 1989, the STD Program will document a chlamydia policy based on the Family Planning and Public Health Laboratory surveillance data.

(see graph next page)

GONORRHEA AGE/SEX SPECIFIC

INCIDENCE RATES/100,000, MONTANA, 1988



Volume: 13:3 **Month of:** MARCH, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

Distributed without charge to health care providers at a cost of 6¢ per copy for printing and 7¢ per copy mailing.

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Montana State Department of Health and Environmental Sciences

Educational Resources Available From the Montana STD Program

A variety of public education and professional pamphlets, booklets, video tapes and films are available from the Montana STD Program. A partial listing of those include:

Public Education
- Some Q & A About Chlamydia
- Herpes Questions/Answers
- So Your Partner Has Herpes
- VD: Women and Babies
- Some Q & A About NGU
- Some Q & A About VD
- Some Q & A About PID
- Q & A About Genital Warts
- STD Prevention for Everyone-16th
- Ineffective Therapies for Genital Herpes Infections (CDC)

Professional
- STD: A Guide for Today's Young Adults-Instructor's Manual and Student's Manual
- Syphilis: A Synopsis (CDC)
- The Laboratory Aspects of Syphilis (CDC)
- Guidelines for the Prevention & Control of Congenital Syphilis
- Sexually Transmitted Diseases Summary (CDC wall chart)
- 1985 STD Treatment Guidelines
- Chlamydia Trachomatis Infections
- Varied Professional Reprints

16 mm Films (DHES Film Library)
- Half Million Teenagers Plus - 1974
- VD and Women (17 min.)
- VD: A Newer Focus - 1977
- VD: Attack Plan (16 min.)
- VD Questions/VD Answers

Videocassettes (1/2 inch)
- Herpes: The Complete Story - 1985
- A Million Teenagers - 1985
- VD: More Bugs, More Problems - 1985

Following are CDC training tapes:
- An STD Interviewing Session
- Gonococcal PID Interview
- Pelvic Inflammatory Disease
- Problem Solving Vignettes
- Barriers to Communication

In addition we have 12 tapes on 3/4 inch (beta) videocassettes.

You may request copies of the above materials or use the audiovisual materials at no charge by writing to the Montana Department of Health and Environmental Sciences, STD Program, Cogswell Building, Helena, MT 59601 or calling 444-4740. If you are aware of pamphlets you would like the STD Program to consider purchasing or reprinting, please send us a copy of the material.

The Burroughs Wellcome Company has developed a guide for the sexually active public on how to give oneself a genital self-examination. A nation-wide advertising campaign is targeted for July 1989, using print and television to offer individuals an opportunity to send for a free GSE Guide.

HEALTHCON

Health professionals can overcome the communication barriers of practicing in a rural area by utilizing HEALTHCON, an electronic bulletin board system developed by the Montana Area Health Education Center. HEALTHCON provides easy access to health information and allows rapid sharing of information between health professionals.

The MESSAGE AREA offers networking possibilities for hospital administrators, public health nurses and others who are often isolated from their colleagues. Utilizing the electronic post office, messages can be sent publicly, for all to read, or privately. The message area can be a convenient way of sharing educational resources. If you need educational resources on a health topic, leave a public message and other users will respond to your request.

The FILES AREA is an electronic library catalogued into 26 different interest areas. Continuing Education Events, Association Newsletters, Employment Opportunities, Legislative News and Rural Health Research are just a few of the topics covered. A physician, for instance, could download a file "What'sUp.Doc" for a listing of workshops just for physicians. A library forum contains directories of numerous resources and in the future Medline searches will be available for those health professionals without library access. Computer-assisted instruction courses are being developed for continuing education credit. SPECIAL FORUMS reserved for special groups encourage "debate" on current issues, while an OPEN FORUM can be utilized for interdisciplinary discussion on topics of general interest.

Need to get information on a health event? The BULLETIN AREA will be used to make announcements regarding health programs, special events, or new information available on the system.

A toll-free number (800-544-2507) or out-of-state number (406-994-2564) provides 24-hour access to HEALTHCON. The system which operates on an IBM-compatible computer, 1200 baud Hayes modem, and Wildcat software is compatible with most combinations of computer, modem or communications software.

Long distances and geographical barriers need not isolate health professionals in Montana from colleagues and other information resources. HEALTHCON can become an important link in the health communication network. For further information, call Marge Levine or Dr. Robert Flaherty at the Montana AHEC office (406-994-6001).

Blood Pressure Equipment Available

The Chronic Disease and Health Promotion Program has blood pressure equipment available for distribution on a first come-first serve basis. The equipment was purchased in 1985 and has not been used. If your local health department is interested, please call Jane Smilie at 444-2640.

Tycos adult cuffs	12
Bowles diaphragm stethoscopes	5
Sonoscope stethoscopes	4
Latex tubing for sphygmomanometer	3
Mercury desk model sphygmomanometer (W.A. Baum Co.)	3
Tycos acoustic sphygmomanometer	1
Child sized latex bag	1
Adult sized latex bags	4
Latex inflation bulb	2
Latex inflation bag	3

Measles Associated Deaths

The following is a brief summary of reported deaths related to measles in the United States: The Centers for Disease Control (CDC) Immunization Division has received reports of 11 measles associated deaths and three suspected measles related deaths since January 1, 1989. Of these 14 deaths, six have been reported among 57 measles cases in American Samoan children residing in the United States. These cases are currently being investigated to obtain more information. The remaining five confirmed deaths have adequate health histories. One was less than 15 months of age and unvaccinated, one was a properly vaccinated leukemic, one was vaccinated in the 1960's with an unknown type of measles vaccine, and two were not vaccinated.

Of the three suspected deaths, one was less than 15 months of age and unvaccinated, one had an inadequate health history, and one was properly immunized.

Of the 14 cases, ten were preschoolers and the remaining cases range from 19 to 29 years of age.

APRIL 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		3		2							1	2		1	
Blaine		5													
Broadwater		2													
Carbon		1													
Carter															
Cascade		32	1	4								1			
Chouteau		1													
Custer		7										1			
Daniels															
Dawson		5													
Deer Lodge		1													
Fallon															
Fergus		2									1	1			
Flathead		7									1			1	
Gallatin	1	50	4		1		1						1		
Garfield															
Glacier		11		4							1			6	1
Golden Valley															
Granite															
Hill		4				1									
Jefferson	1														
Judith Basin															
Lake		4													
Lewis & Clark		20	1												
Liberty															
Lincoln		4													
McCone															
Madison															
Meagher															
Mineral															
Missoula		17	1	1		2							1		
Musselshell		1													
Park		1									1				
Petroleum															
Phillips															
Pondera															
Powder River											1				
Powell		3													
Prairie															
Ravalli		1		1											
Richland				1											
Roosevelt		10		7							1			2	
Rosebud		5		1											
Sanders		1													
Sheridan		1													
Silver Bow	1	10	1												
Stillwater															
Sweet Grass	1														
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		45		2								1			
MONTHLY TOTAL 1989	4	*256	8	23	1	3	1	0	0	0	7	6	2	10	1
MONTHLY TOTAL 1988	4	134	4	52	0	1	5	1	1	0	6	27	7	5	0
MONTHLY TOTAL 1987	1	132	17	44	0	8	9	1	0	0	9	25	2	0	0
TOTAL TO DATE 1989	11	504	32	81	2	15	16	1	0	1	22	26	21	58	5
TOTAL TO DATE 1988	11	702	48	158	4	17	20	4	3	0	25	90	20	20	0
TOTAL TO DATE 1987	2	449	50	182	7	22	17	6	1	0	24	68	11	11	8

OTHER DISEASES: Chickenpox: Cascade, 2; Dawson, 14; Madison, 8; Park, 2; Silver Bow, 3; Yellowstone, 35
Cytomegalo Viral Illness: Missoula, 3
Mumps: Gallatin, 1
*Chlamydia numbers are for March and April combined.

Two Common Influenza Questions: Efficacy of Influenza Vaccine, And the Influenza-Aspirin-Reye's Syndrome Linkage

Summarized below is evidence which indicates that taking influenza vaccine annually in the fall is beneficial for senior citizens and others in high-risk groups.

Howells, et al (Lancet 1975; 1:381-3) found that in a United Kingdom study the case-fatality rate of bronchopneumonia in the elderly was lower in influenza vaccinees than in non-vaccinees. Goodman, et al (JAMA 1982; 247:1451-3) investigated a nursing home influenza A outbreak where influenza immunization was associated with a borderline significant ($p=0.07$) trend toward reduced influenza illness and mortality. Patriarca, et al (JAMA 1985; 253-1136-9) studied influenza A outbreaks in seven nursing homes and found that non-vaccinees were 2.6 times more likely to become ill, and if ill, 2.4 times more likely to develop pneumonia and 5.6 times more likely to die than were vaccinees. Saak, et al (Arch Intern Med 1986; 145:2353-7) performed a retrospective cohort study in a nursing home over three consecutive influenza seasons, finding that, when influenza A or B was present in the community, case-fatality rates for pneumonia were three times higher in non-vaccinees compared to vaccinees.

Arden, et al (In Kendal AP, Patriarca PA: Options for Control of Influenza. New York: Alan R. Liss, 1986) reviewed a total of 20 published and unpublished studies of nursing home influenza outbreaks (including two of those cited above), and found that most showed evidence of vaccine efficacy, though in some instances the benefit was manifested in reduction in illness severity but not in illness incidence. Further, Barker and Mullooly (JAMA 1980; 244:2547-9) studied elderly persons who were not institutionalized but who had chronic illnesses, finding that, when the strains of viral antigen included in the vaccine closely matched the then-circulating epidemic strains of influenza virus, influenza immunization was associated with a 70% reduction in pneumonia and influenza-related hospitalizations and an 85% reduction in mortality associated with the same causes. In summary, while the immune response to influenza vaccine may be less vigorous in the elderly and while in some years the vaccine does not match well one or more circulating strains of influenza virus, in general influenza immunization of the elderly reduces serious influenza morbidity and mortality.

With regard to influenza, aspirin (acetylsalicylates) and Reye's Syndrome (also called Reye Syndrome), six case-control studies of children and teenagers have demonstrated a strong association between Reye's Syndrome and taking aspirin during the respiratory or chicken-pox illness that preceded the Reye's Syndrome onset. The most well-known of these was the U.S. Public Health Services study (Hurwitz ES, et al: JAMA 1987; 257:1905-11) which found aspirin usage for such antecedent illnesses in children and teenagers to be associated with a 26-fold increase in Reye's Syndrome risk and also developed evidence indicating that a majority of Reye's Syndrome cases may be attributed to aspirin use. Data from the same study but published separately also indicated that, while greater doses of aspirin increased the Reye's Syndrome risk, no safe dosage level of aspirin dosage could be demonstrated (Pinsky PF, et al: JAMA 1988; 260:657-61).

Published warnings that children and teenagers should avoid taking aspirin-containing medications for chickenpox and influenza-like illness appear to be having a significant effect. Two-surveys indicate that during the first half of the 1980's decade the percentage of parents aware of this warning rose, the frequency of salicylate use for viral illness among children dropped, and the incidence of Reye's Syndrome markedly declined (Barrett MJ, et al: Pediatrics 1986; 77:598-602. Sienko DG, et al: JAMA 1988; 258:3119).

From: California Morbidity, December 30, 1988 #51.

Rabies Vaccine Given IM Post-exposure

The April 7, 1989 Volume 38, Number 13, Morbidity and Mortality Weekly Report is related to recommendations on immunization. The report is easy to read and concise. However, there is a mistake on page 207 of the report in table 1. Table 1 entitled "Vaccines Available in the United States by Type and Recommended Routes of Administration" has an error, in the information regarding rabies vaccine.

The table is done in a manner in which vaccines are listed in the left hand column in alphabetical order. Therefore, rabies is the 15th product listed in the first column. The third column or the column on the right hand side of the table is relative to route for administration of the type of vaccine. Route in the table states that rabies vaccine is given subcutaneous or intradermal and then there's reference to a footnote. The footnote is correct. Pre-exposure rabies vaccine is given intradermally. However, post-exposure rabies vaccine must be given intramuscularly, not subcutaneously.

There has been concern in the past that rabies vaccine be given only in the deltoid to ensure intramuscular injection. Persons having received post-exposure rabies vaccine in the gluteal area in which muscle mass may not be touched by the needle, have developed antibodies in a lesser amount than persons given the vaccine in the deltoid where the muscle is more surely reached. Persons receiving post-exposure rabies vaccine must be given a 1 ml dose into muscle mass. Please make this change to your April 7, 1989 MMWR in Table 1 on page 207. The MMWR will be issuing an erratum related to this matter.

* *
* HIV/AIDS INFORMATION *
* *

TREATMENT AND RESEARCH

Comparison of Fluconazole and Ketoconazole for Oropharyngeal Candidiasis in AIDS

Abstract: In a randomized, double-blind study the efficacy and toxicity of oral fluconazole 50 mg daily and ketoconazole 200 mg daily were compared for the treatment of oropharyngeal candidiasis in patients with acquired immunodeficiency syndrome (AIDS) and AIDS-related complex (ARC). 20 episodes (18 patients) were treated with fluconazole and 20 episodes (19 patients) with ketoconazole. Pretreatment clinical features and laboratory test results were similar in both groups. 17 episodes (85%) in the fluconazole group and 16 (80%) in the ketoconazole group could be evaluated. There was clinical cure at the end of therapy in all fluconazole-treated and 12 of 16 (75%) ketoconazole-treated episodes. Cultures were negative at the end of therapy in 87% of the fluconazole group and 69% of the ketoconazole group. 1 patient stopped taking fluconazole because of severe nausea. 1 of 18 fluconazole-treated and 4 of 19 ketoconazole-treated patients had transient rises in alanine or aspartate aminotransferase. Fluconazole seemed more effective than ketoconazole in the treatment of oral thrush among AIDS and ARC patients.

(DeWit, S., et al, Lancet, April 8, 1989, Vol. 1, p. 746-747.)

Ganciclovir Update

The Anti-Infective Drug Advisory Committee, a panel of outside experts, has recommended to FDA that the agency approve ganciclovir (DHPG). Ganciclovir gas been an experimental therapy for AIDS patients with cytomegalovirus retinitis, an eye infection that can lead to blindness.

Ganciclovir has been made widely available to AIDS patients with cytomegalovirus retinitis through a Treatment IND sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) and other protocols sponsored by Syntex and NIAID. Physicians who currently have patients that they feel may benefit from the drug should call the Ganciclovir Study Center at (301) 497-9888.

Vaccine Changed to Treatment

On March 9, 1989, FDA granted permission to test the experimental AIDS vaccine, VaxSyn HIV-1, as a treatment for AIDS virus-infected individuals who have not yet manifested symptoms of the disease. VaxSyn HIV-1, which in August 1987 became the first experimental vaccine to be cleared for clinical testing to prevent AIDS infection, will be studied as a means for bolstering the immune system of AIDS virus infected individuals who are asymptomatic.

The genetically engineered vaccine contains the gp 160 protein found on the AIDS virus envelope. The vaccine's developer, MicroGeneSys Inc. of West Have, Conn. (203 932-3203) will sponsor this new study, which is to be conducted at Walter Reed Army Medical Center.

TRANSMISSION

HIV Transmission to Sexual Partners Of People with Hemophilia

Three studies published in 1988 conclude that there is a low frequency of heterosexual transmission of HIV from seropositive people with hemophilia to their long-term sexual partners and that the reasons for this are unclear.

Researchers from Worcester, Massachusetts (Archives of Internal Medicine, June 1988) investigated the intimate household contacts of 68 seropositive hemophiliacs, including 36 sexual partners, and found all to be seronegative, including six partners of people with hemophilia from whom the virus itself was isolated, and six partners of hemophiliacs with AIDS. The low transmission rate may be related to the lower incidence of sexually-transmitted diseases among hemophiliacs and their partners than among IV drug users or gay men.

Researchers from the University of Pittsburgh (Public Health Reports, January-February 1988) found that four (19 percent) of the female partners of 21 seropositive men with hemophilia were seropositive. None admitted other risks for HIV infection or prior incidence of sexually-transmitted diseases. HIV itself was isolated from the lymphocytes of only one hemophiliac and one female partner. Seropositive female partners were younger, had younger hemophiliac partners, and were more likely to engage in oral sex and to have had more than one sexual partner in the previous five years. The low incidence of HIV infection may be due to the low rate of HIV isolation and infectivity among the hemophiliacs.

In support of this conclusion, a New Jersey study (American Journal of Medicine, October 1988) found only one out of 14 wives of seropositive hemophiliacs was HIV-infected, and that her husband had been reactive for HIV antigen for 26 months.

(FOCUS: A Guide to AIDS Research, April 4, 1989, Vol. 4, No. 5, p. 4.)

The Risk of Tuberculosis Among IVDU With HIV Infection

Abstract: To determine the risk of active tuberculosis associated with human immunodeficiency virus (HIV) infection, we prospectively studied 520 intravenous drug users enrolled in a methadone-maintenance program. Tuberculin skin testing and testing for HIV antibody were performed in all subjects.

Forty-nine of 217 HIV-seropositive subjects (23 percent) and 62 of 303 HIV-seronegative subjects (20 percent) had a positive response to skin testing with purified protein derivative (PPD) tuberculin before entry into the study. The rates of conversion from a negative to a positive PPD test were similar for seropositive subjects (15 of 131; 11 percent) and seronegative subjects (26 of 202; 13 percent) who were retested during the follow-up period (mean, 22 months). Active tuberculosis developed in eight of the HIV-seropositive subjects (4 percent) and none of the seronegative subjects during the study period (P 0.002). Seven of the eight cases of tuberculosis occurred in HIV-seropositive subjects with a prior positive PPD test (7.9 cases per 100 person-years, as compared with 0.3 case per 100 person-years among seropositive subjects without a prior positive PPD test: rate ratio, 24.0:P 0.0001).

We conclude that, although the prevalence and incidence of tuberculosis infection were similar for both HIV-seropositive and HIV-seronegative intravenous drug users, the risk of active tuberculosis was elevated only for seropositive subjects. These data also suggest that in HIV-infected persons tuberculosis most often results from the reactivation of latent tuberculosis infection; our results lend support to recommendations for the aggressive use of chemoprophylaxis against tuberculosis in patients with HIV infection and a positive PPD test.

(Jeluyn, Peter A, et al, N Engl J Med, 1989; 320:545-50.)

TRENDS

AIDS Cases Reported to WHO as of April 4, 1989

Continent	Total
Africa	19,141
America	101,831
Asia	360
Europe	19,817
Oceania	1,360
TOTAL	146,569

Counseling Issues for People With Hemophilia and HIV Infection

HIV infection has drastically altered the world of hemophiliacs, who, thanks to a treatment network and the development of clotting factors, had become able to treat themselves at home and feel more independent, writes clinical social worker Debra DeMaio. Appropriate counseling for HIV-infected hemophiliacs must be aware of the psychological challenges these people face. In many people, the combination of AIDS and the complications of hemophilia results in isolation, dependency on the family, anger at the medical system, and fear of disclosure of hemophilia and HIV infection. HIV-positive children and adolescents with HIV infection also have special needs. Among hemophiliacs, common responses include fears about maintaining intimacy and forming new relationships. Some resist safe sex techniques, but others may choose abstinence. Many HIV-positive hemophiliacs have moved past denial and adapted the philosophy that the hemophiliac is his own primary care giver to their approach to HIV infection, DeMaio writes.

(DeMaio, Debra. Focus: A Guide to AIDS Research, 04/89, Vol. 4, No. 5, p. 3.)

RESOURCES

A Guide to Experimental AIDS Treatments

The American Foundation for AIDS Research (AmFAR) publishes a quarterly "AIDS/HIV Experimental Treatment Directory." This directory is to assist people with AIDS and their physicians in making decisions about therapeutic options. It lists the location of clinical trials and the latest findings on over 60 experimental AIDS drugs. Included with each listing is an explanation of how the drug works, possible side effects and other important data.

The Montana AIDS/STD Program receives this publication and it is available for loan or as a resource by calling 444-4740.

National AIDS Hotline Announces Its TTY Service for Deaf People

1-800-AIDS-TTY
(1-800-243-7889)

The Hotline has information specialists who are trained to give private information about places to go for help related to AIDS.

CONFERENCES

HIV Counselor Course

The Montana AIDS/STD Program will sponsor the HIV Counselor Course in Helena on June 21 and 22, 1989. The course is designed to teach those who may be performing the HIV test how to provide sensitive pre- and post-test counseling. There is no fee to attend the course. For information on registration, please contact BJ Combest at 444-3774.

National AIDS Network Skills Building Conference

The National AIDS Network Skills Building Conference will be November 2-5, 1989 at Omni Shoreham Hotel in Washington, D.C. For more information, call the National AIDS Network at (202) 293-2437.

Seminar

The Recovery Foundation, Inc. and Montana AHEC will be co-sponsoring a seminar, "AIDS: Clinical Issues in the Therapeutic Setting" June 21-23, 1989 in Missoula at St. Patrick Hospital. The cost of the course is $125.00. For more information, please contact Pamela B. Anderson at (406) 721-1880.

***MONTANA**
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 04/15/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	19 (48)	8 (40)
Other Disease w/o PCP	19 (48)	12 (60)
KS Alone	2 (4)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	40 (100)	20 (50)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	12 (30)
30-39	18 (45)
40-49	7 (17)
Over 49	3 (8)
Unknown	0 (0)
Total	40 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	36 ( )
Black, Not Hispanic	1 (3)
Hispanic	2 (4)
Other	1 (3)
Unknown	0 (0)
Total	40 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	24 (65)	0 (0)	24 ( )
Intravenous (IV) Drug User	4 (11)	0 (0)	4 (10)
Homo/Bi IV Drug User	4 (11)	0 (0)	4 (10)
Hemophiliac	2 (6)	0 (0)	2 (5)
Heterosexual Contact	0 (0)	3 (100)	3 (8)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (7)	0 (0)	3 (8)
Total	37 (100)	3 (100)	40 (100)

Source: Montana AIDS Program, MDHES, March 15, 1989

*Includes 27 Montana AIDS cases and 12 cases reported to Centers for Disease Control from other states who are living in Montana.

As of April 30, 1989 there have been 193 positive HIV tests from 14,821 tests conducted through the MDHES Public Health Laboratory.

Volume: 13:5 **Month of:** APRIL, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

Distributed without charge to health care providers at a cost of 6¢ per copy for printing and 7¢ per copy mailing.

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VOLUME: 13:6 MONTH OF: May, 1989

Montana State Department of Health and Environmental Sciences

Immunizations for International Travel

At this time of the year, more people are travelling outside of the United States. Requests for information regarding immunization requirements also increase. Persons planning to travel should be urged to check on immunization advice at least a month before they plan to travel.

Many people have misconceptions about immunizations for travel. There are no immunizations required to re-enter or enter the United States. Popular international vacation spots such as the U.S., England, France, Canada, Italy and Ireland, require no immunizations of visitors. Small pox vaccination is no longer required of travellers anywhere in the world. Required immunizations sometimes vary depending on the order in which multiple countries will be visited. Therefore, it's important to know the itinerary of a person requesting information about international travel vaccination.

The recommended preventive health measures for travellers are sometimes more important than the required ones. Countries institute vaccine requirements to protect their own citizens, not foreign travellers. For the most part, people do not need to obtain an array of exotic and expensive vaccinations but need to check on routine immunizations such as protection against tetanus and measles. There are guidelines for appropriate immunization at every age and these should be consulted.

Visitors to foreign countries where risks of infection with enteric diseases is greater than the United States should be instructed to not consume raw water or food products. The use of immune serum globulin in place of practicing hygiene is not encouraged.

Malaria prophylaxis is advisable for travel to some countries, including parts of Mexico. Prophylaxis varies depending upon whether the malaria in the area is chloroquine resistant or not. There are sections of countries where malaria prophylaxis is recommended and other parts of the same country may require no malaria prophylaxis. The requirements set forth in the book, Health Information for International Travel, 1988, published by the U.S. Centers for Disease Control (CDC) needs to be consulted to advise a person appropriately regarding malaria prophylaxis.

Persons working in countries with endemic rabies in domestic and wild animals should consider having pre-exposure rabies vaccine before leaving the United States. This will offer them some protection as well as reducing the risk of inappropriate post-exposure rabies vaccine if that need occurs.

Persons travelling with infants should be aware that travel to developing nations for children under six months of age is not advised. If the travel is unavoidable, a physician might order a speed up in the time intervals for routine childhood immunizations.

Questions concerning international travel can be directed to the Communicable Disease Section of the Preventive Health Services Bureau at MDHES. The CD Section can be contacted by phoning 444-4740.

MAY 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1		1										2	
Big Horn		3										2			
Blaine		1													
Broadwater															
Carbon															
Carter															
Cascade		26		2			1		1			1	1		
Chouteau			1												
Custer		4													
Daniels															
Dawson															
Deer Lodge															
Fallon															1
Fergus		1													
Flathead		4													
Gallatin	4	10	1								1				
Garfield															
Glacier		3	2	1										1	1
Golden Valley															
Granite															
Hill		4												1	
Jefferson															
Judith Basin												1			
Lake		3													
Lewis & Clark	2	8	2	1		1	1								
Liberty															
Lincoln		2		1							1				
McCone												2			
Madison															
Meagher															
Mineral															
Missoula		12			1	1					1				
Musselshell		1	1												
Park	1														
Petroleum															
Phillips		1													
Pondera															
Powder River															
Powell															
Prairie															
Ravalli		1													
Richland				1			1								
Roosevelt		3												1	
Rosebud		3		1											1
Sanders															
Sheridan												1			
Silver Bow		3	1								1				
Stillwater															
Sweet Grass				1											
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone	1	21	1	4								1	1		
MONTHLY TOTAL 19 89	8	115	9	13	1	2	3	0	1	0	4	8	2	5	3
MONTHLY TOTAL 19 88	4	184	13	35	0	4	4	2	0	0	2	23	8	20	0
MONTHLY TOTAL 19 87	6	144	8	41	2	5	8	1	1	0	19	18	11	0	0
TOTAL TO DATE 19 89	19	619	41	94	3	17	19	1	1	1	26	34	23	63	8
TOTAL TO DATE 19 88	15	886	61	193	4	21	24	6	3	0	28	113	28	40	0
TOTAL TO DATE 19 87	8	593	58	223	9	27	25	7	2	0	43	86	22	11	8

OTHER DISEASES: Aseptic Meningitis: Gallatin, 2; Chickenpox: Cascade, 9; Dawson, 1; Lewis & Clark, 3; Madison, 13; Yellowstone, 32; Colorado Tick Fever: Park, 1; Rocky Mountain Spotted Fever: Missoula, 1; Ravalli, 1; Yellowstone, 1; Primary Syphilis: Big Horn, 1; Late Latent Syphilis: Stillwater, 1

Resistant Gonorrhea Recommendations -- SE Montana

No new cases of penicillinase-producing resistant gonorrhea (PPNG) have been reported in the state since the last two cases reported from Yellowstone County in February 1989. Therefore, the previous recommendations of the MDHES STD Program to treat all gonorrhea patients in southeastern Montana with ceftriaxone or spectinomycin, followed by doxycycline or tetracycline, is modified as follows:

Continue to treat with the above alternate regimen.

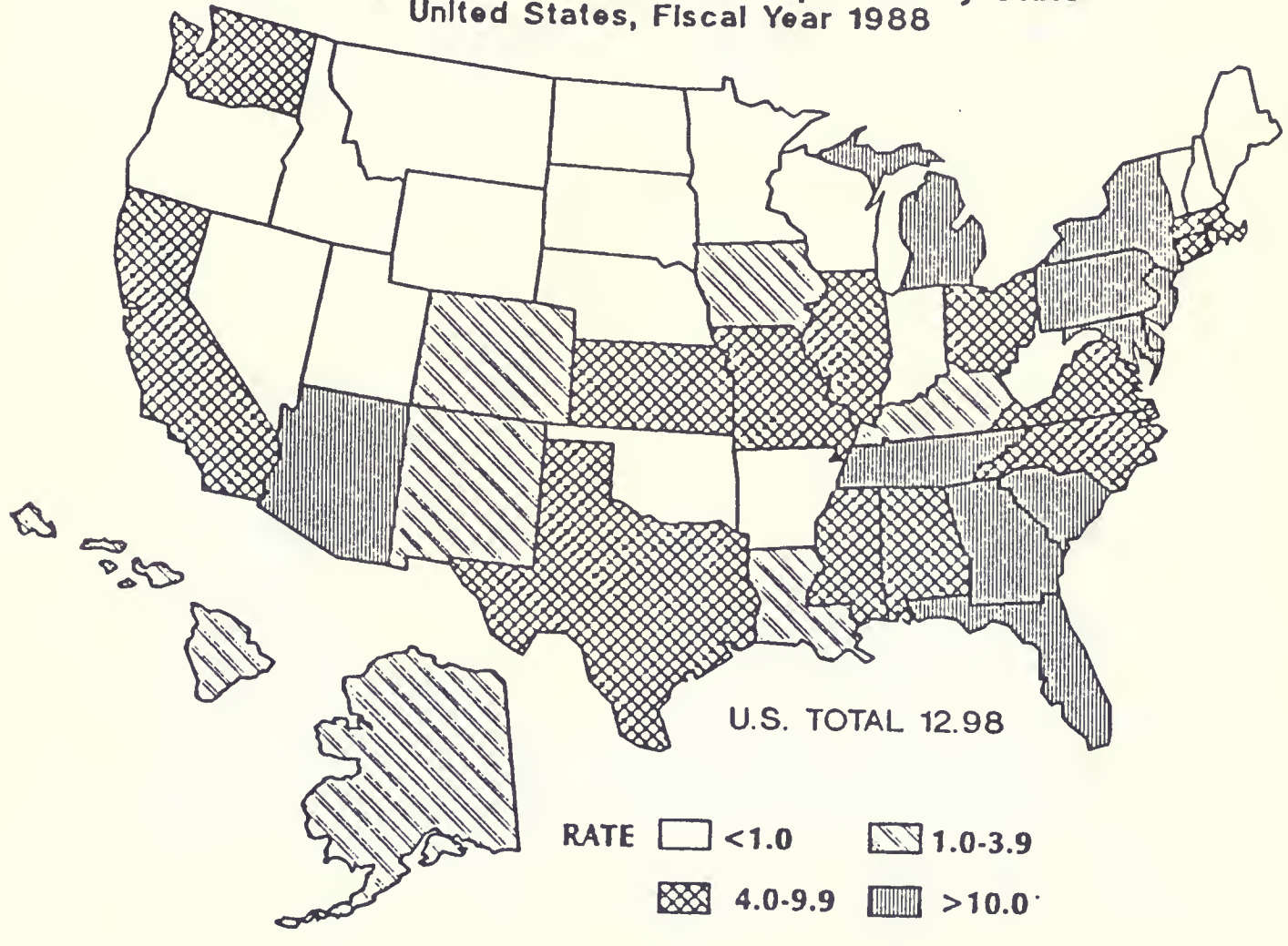
1. Any symptomatic patients (male or female) who are not cultured for gonorrhea, or

2. any patients whose positive cultures are not tested for beta-lactamase production by your local laboratory, or

3. any gonorrhea patients with a history of travel (within 60 days) to foreign or domestic areas with a high prevalence of PPNG (see Figure 7) or with a recent exposure to prostitutes.

Report all gonorrhea cases immediately to your local public health agencies.

Figure 7. Antibiotic Resistant Gonorrhea Reported Cases per 100,000 Population by State United States, Fiscal Year 1988



Syphilis Outbreak - Yellowstone County

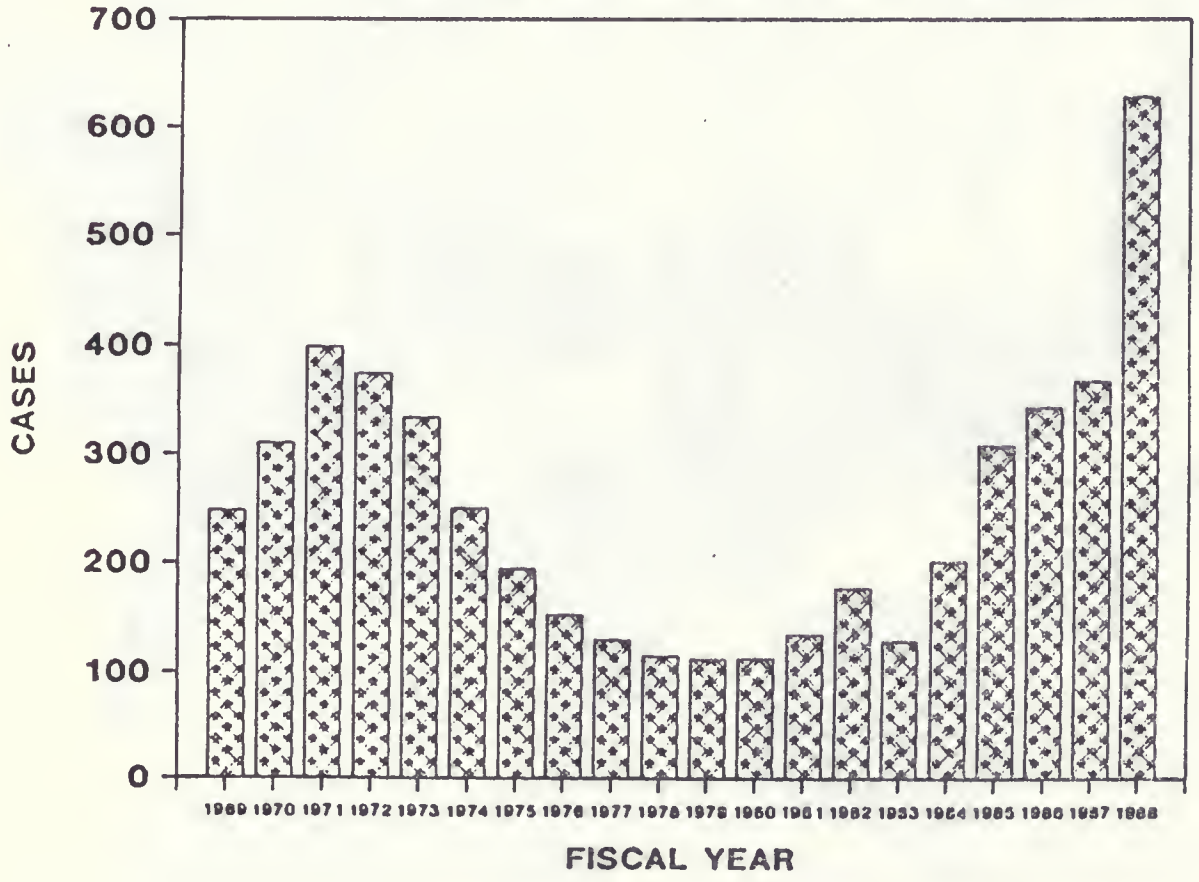
Three cases of early syphilis have been reported in the Yellowstone County area in early June, with the source a local prostitute in Billings. The source is determined to have been infectious in April 1989 and was unable to identify any of her business contacts. With an average three week incubation period, those contacts should have developed primary symptoms in May. Of the 11 contacts named in this outbreak, nine have been examined and epidemiologically treated. The index patient and a contact of the third patient were both two months pregnant. Congenital syphilis was probably prevented as a result of this investigation.

Early syphilis morbidity increased nationally by 17% in FY 1988, to the highest level since 1949. Predictably, infant congenital syphilis cases increased to 628 cases in this country, up 70% from the cases reported in FY 1987. (See Figure 20). During the past two years, this increase has occurred in low-income, inner-city, heterosexual minority populations. Syphilis in white, homosexual males has decreased since 1982.

Part of this increase in disease nationally is a result of increased usage of alternative therapy for resistant gonorrhea that does not abort incubating syphilis. Another reason is the hard-to-reach foci of disease among "crack" cocaine users who are exchanging sex for drugs.

Figure 20. Congenital Syphilis Under One Year of Age

United States, Fiscal Years 1969 - 1988



HIV/AIDS INFORMATION

TREATMENT AND RESEARCH

Treatment and Prophylaxis of Isospora belli infection in patients with AIDS

Abstract: Enteric infection with the protozoan Isospora belli is common in patients with the acquired immunodeficiency syndrome (AIDS) and causes severe diarrhea. I. belli responds well to treatment with trimethoprim-sulfamethoxazole, but there is a high rate of recurrence. To investigate the effect of long-term prophylaxis, the authors studied 32 Haitian patients with AIDS complicated by I. belli infection and chronic diarrhea. All were treated with trimethoprim (160 mg) and sulfamethoxazole (800 mg), given orally four times a day for 10 days; the patients were then randomly assigned to receive 500 mg of sulfadoxine and 25 mg of pyrimethamine weekly, 160 mg of trimethoprim and 800 mg of sulfamethoxazole three times a week, or placebo.

Half of the patients (5 of 10) who received placebo had recurrent, symptomatic isosporiasis a mean of 1.6 months after the initial treatment. All 22 patients who received either trimethoprim-sulfamethoxazole or sulfadoxine-pyrimethamine remained asymptomatic. I. belli was identified in stools of only one of these patients, who was receiving trimethoprim-sulfamethoxazole. The study medications were generally well tolerated but had to be discontinued in the cases of two patients because of severe pruritus. In 10 patients, the prophylactic regimen has been continued for a mean of 16 months without recurrent isosporiasis.

It was concluded that isosporiasis in patients with AIDS can be treated effectively with a 10-day course of trimethoprim-sulfamethoxazole and that recurrent disease can subsequently be prevented by ongoing prophylaxis with either trimethoprim-sulfamethoxazole or sulfadoxine-pyrimethamine. (Papa, Jean W., M.D., et al, N. Engl. J. Med. 1989; 320:1044-7).

AIDS and the Nervous System

In addition to being lymphotropic--causing immunodeficiency -- HIV is also neurotropic, able to affect both the central and peripheral nervous system. HIV-related neurological illness often appears early in the course of HIV infection. Autopsies show that more than 80 percent of adult patients with AIDS have neuropathological abnormalities. At least half of them have some clinical neurological disorder during the course of their illness. HIV-infected people are subject to infections caused by primary infections of the CNS with HIV, or by opportunistic viral or bacterial infections. A small percentage of HIV-infected patients suffer primary CNS lymphomas and cerebrovascular disorders. Up to 80 percent show symptoms of neuropathies or myopathies. AZT may improve AIDS dementia, according to some studies. Plasmapheresis has benefited some patients with inflammatory demyelinating polyneuropathies.

(Dalakas, Marinos, Journal of the American Medical Association (04/28/89), Vol. 261, No. 16, p. 2396)

ADRP Program Suspended

The Montana Department of Health and Environmental Sciences' program that used federal funds to purchase zidovudine (AZT) for persons suffering symptoms of HIV infection is being suspended. The suspension of benefits is effective July 31, 1989 and is due to the lack of federal funds to continue the program. The AIDS Drug Reimbursement Program (ADRP) is only being suspended at this time rather than terminated. Suspension will allow for the immediate re-establishment of services should new funds become available. Persons with HIV infection and whose physician certifies that AZT therapy would be beneficial can still apply for ADRP assistance, however, they will not be enrolled in the program unless new funds are made available. MDHES has operated the ADRP since January 1988. The first client was served in June 1988 and a total of 14 persons have received either full or partial costs for AZT. Currently, 7 persons use the program to pay their costs for AZT.

For more information about the AIDS Drug Reimbursement Program, contact the Montana Department of Health and Environmental Sciences' AIDS/STD Program.

Acquired Immunodeficiency Syndrome Associated with Intravenous Drug Use -- United States, 1988

Reported AIDS cases among IV drug users (IVDUs), their sex partners, and children born to IVDUs or the sex partners of IVDUs totaled 9,752 in 1988, the Centers for Disease Control reports. IVDU-related cases accounted for 33.3 percent of the 32,311 AIDS cases reported in 1988. The cases break down as follows: 5,789 male heterosexual IVDUs (53.9 percent); 1,742 female IVDUs (16.2 percent); 2,055 male homosexual/bisexual IVDUs (19.1 percent); 227 men whose heterosexual partners were IVDUs (2.1 percent); 620 women whose heterosexual partners were IVDUs (5.8 percent); 231 children whose mothers were IVDUs (2.1 percent); and 83 children whose mothers were sex partners of IVDUs (0.8 percent). Blacks and Hispanics continue to have higher rates of IVDU-associated HIV transmission, particularly in the Northeast. Outside of the AIDS Case Definition, HIV-infected IVDUs die more frequently of pneumonia, endocarditis, and pulmonary tuberculosis than non-infected IVDUs.

(Journal of the American Medical Association, 04/28/89, Vol. 261, No. 16, p. 2314)

NIAID Opens Toll-Free AIDS Clinical Trials Information Service

The National Institute of Allergy and Infectious Diseases has established a new NIAID AIDS Clinical Trials Information Service. The computerized service provides current information, free of charge, about clinical trials sponsored by the National Institutes of Health (NIH) for AIDS patients and others infected with the human immunodeficiency virus (HIV).

Callers may reach the service by dialing 1-800-TRIALS-A, Monday through Friday between 9:00 a.m. and 7:00 p.m., e.d.t.

Physicians and other health practitioners, as well as patients and their families, may call the toll-free service for specific information about NIH-sponsored clinical trials of experimental therapies for AIDS and AIDS-related diseases. Information will be provided directly and immediately by telephone, and callers may request to speak with a Spanish-speaking health specialist. On request, callers may also obtain computer printouts from custom searches of the data base. All communication with the service is completely confidential.

RESOURCES

Her Giveaway: A Spiritual Journey With AIDS

This is the story of Carole LaFavor, an Ojibwa woman with AIDS. The video combines a strong sense of Native American traditionalism along with narration that outlines clinical and psycho-social issues around AIDS. 25 minutes.
Contact: MDHES AIDS/STD Program
444-4740

David's Song

The video is designed as a trigger tape to promote discussion and raise questions about AIDS and its impact. The video documents an interview with David Woodring, an Osage man with AIDS responding to Pueblo Indian high school students. Designed for teens. 13 minutes.
Contact: Ken Hunt or Helen Tso
Center for Indian Youth Program
Department of Pediatrics
School of Medicine
University of New Mexico
2710 Frontier, N.E.
Albuquerque, NM 87131
(505) 272-5551

AIDS News

A color comic book developed for minority youth. All characters are people of color and the high school sex education teacher depicted in the comic's story is a Native American woman with American Indian students in the classroom.
Contact: People of Color Against AIDS Network
105 14th Avenue
Seattle, WA 98122
(206) 322-7061

The Impact of AIDS in the Native American Community

This book provides a comprehensive look at the impact of HIV infection on Native

American communities, including high risk behaviors, health and health care, and issues related to women and AIDS. Includes a model policy statement for health boards and tribal councils. Prepared by Tracey Easthope and Charon Asetoyer.

Contact: The Native American Women's Health Education Resource Center
P. O. Box 57
Lake Andes, SD 57356-0572
(605) 487-7072

Mom and Son Series

This brochure includes information about AIDS for parents and other adults seeking to educate Native American children, grades K-5, about AIDS.

Contact: The Native American Women's Health Education Resource Center
P. O. Box 57
Lake Andes, SD 57356-0572
(605) 487-7072

New Journal Launched: AIDS Education and Prevention

AIDS Education and Prevention, the official journal of the International Society for AIDS Education, is a new quarterly taking an interdisciplinary approach to AIDS issues. The journal will focus on the development, implementation, and evaluation of existing and theoretical models of AIDS education and prevention. Guilford Press in New York will publish the journal.

(American Journal of Public Health, 5/89, Vol. 79, No. 5, p. 651)

Free AZT

Burroughs Wellcome, manufacturer of AZT, funds a program to distribute this expensive drug free of charge to qualifying PWA's as part of its **Patient Temporary Assistance Program.** Available on a three-month renewable basis, the program stipulates that PWA's who may qualify should ask their physicians to write to Burroughs Wellcome requesting an application. Pending approval, free AZT is then shipped monthly to the patient for three months. If the patient's financial situation is unchanged after 90 days, he may continue in the program, but must re-apply. The re-application procedure is a simpler process. Interested persons are encouraged to contact Lisa Behrens at 1-800-722-9292, ext. 3633.

Books for the Taking

Supplies of "You Can Do Something About AIDS," which the book publishing industry produced last year, are nearly exhausted. However, the Stop AIDS Project, Inc., which coordinated the book's publication, continues to make copies available for interested groups and individuals. For 100 copies, the cost is $35, and for five copies, the cost is $5. People or organizations can send for the book, which includes brief sections by Whoopi Goldberg, Elizabeth Taylor, Greg Louganis, and other celebrities, by writing the Stop AIDS Project, Inc. at 40 Plympton Street, Boston, MA 02118.

TRENDS

The San Francisco group Pets are Wonderful Support (PAWS) has developed "safe pet guidelines" for people with AIDS (PWAs) who want an animal's companionship. The first guidelines deal with keeping your pet healthy, including regular veterinarian visits and up-to-date vaccinations. Those with immune system problems should minimize the risk of contracting any infections by washing their hands after handling pets and using gloves and bleach solutions to clean up any "messes." Pets should have short nails. If a pet scratches or bites an HIV-positive or immune-compromised person, the wound should be washed thoroughly with soap and water. Younger animals and strays are more likely to carry infections. Although many people with AIDS fear developing toxoplasmosis from cats, cats who eat only commercial cat food and remain indoors are less likely to become infected. Litter boxes should not be nearing the kitchen or dining area. People not at risk should change the litter, if possible. PAWS also recommends that people arrange in advance for friends and neighbors to care for their pets when necessary.

(Helquist, Michael, Advocate, 3/14/89, p. 24)

Accumulated AIDS Cases Reported to WHO Through April 1989

African Region:	23,043
American Region:	101,831
Eastern Mediterranean Region:	218
European Region:	19,911
South East Asia Region:	46
Western Pacific Region:	1,515
	146,569

***MONTANA**
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 05/22/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	20 (45)	8 (40)
Other Disease w/o PCP	21 (48)	13 (62)
KS Alone	3 (7)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	44 (100)	21 (48)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	14 (32)
30-39	19 (43)
40-49	7 (16)
Over 49	4 (9)
Unknown	0 (0)
Total	44 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	40 (91)
Black, Not Hispanic	1 (2)
Hispanic	2 (5)
Other	1 (2)
Unknown	0 (0)
Total	44 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	27 (66)	0 (0)	27 (61)
Intravenous (IV) Drug User	4 (10)	0 (0)	4 (9)
Homo/Bi IV Drug User	5 (12)	0 (0)	5 (11)
Hemophiliac	2 (5)	0 (0)	2 (5)
Heterosexual Contact	0 (0)	3 (100)	3 (7)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (7)	0 (0)	3 (7)
Total	41 (100)	3 (100)	44 (100)

Source: Montana AIDS Program, MDHES, May 22, 1989

*Includes 31 Montana AIDS cases and 13 cases reported to Centers for Disease Control from other states who are living in Montana.

As of May 31, 1989 there have been 194 positive HIV tests from 15,282 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of April 30, 1989, 94,280 cases of AIDS and 54,402 deaths have been reported to the Centers for Disease Control.

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Immunization Law Amended

The Montana Immunization Law was amended by the 1989 Legislature as follows:

1. It broadens the application of the law from only K-12 schools to other educational settings (colleges, vo-tech centers and preschools).

2. The personal exemption was removed (for all settings).

3. Mumps is included. Testimony on the bill indicated that mumps will be required only for those entering school (kindergarten or first grade).

4. A religious exemption is still allowed as follows:

   a. It must be reasserted each year by affidavit (notarized).

   b. Includes language stating that immunization is contrary to the religious tenets and practices of the signer.

   c. False claims subject to the penalty for false swearing.

   NOTE: A form is being developed for use of the exemption.

5. Removed the 30 day grace period for transfers:

   a. Students must have an immunization record, in hand, to attend school.

   b. Schools may photocopy immunization records.

   c. School of transfer has to accept the photocopy.

   d. School of origin shall forward the original record to the school of transfer within 30 days.

6. For those excluded from school during an outbreak, the 30 day exclusion period is removed and students are excluded from school until the excluding authority is satisfied that the person no longer risks contracting or transmitting that disease.

Other new sections in the law:

7. Extension of authority to make rules subject to this law.

8. Severability -- if a part of the law is challenged and found invalid, the rest of the law remains in effect.

9. Effective date is July 1, 1989.

The Administrative Rules are being rewritten to reflect changes in the law. However, the rule making process does not affect the law. Questions about the law should be directed to the Montana Immunization Program (444-4740).

Rubella VIP Registry Discontinued

The Registry of susceptible women who received rubella vaccine just prior to or during pregnancy will no longer be maintained by the Division of Immunization, Centers for Disease Control (CDC), and will no longer be requested by the Montana Immunization Program. This monitoring program ceased on April 30, 1989. Women already registered will continue to be followed. Based upon information collected from the registry (begun in 1971), it is concluded that rubella vaccine risks to the fetus are negligible. This announcement appears in the May 5, 1989 MMWR. Please inform appropriate health care professionals who deal with these issues that future reporting of pregnant women who received rubella vaccine will not be necessary.

Electronic Service For Inquiries About the MMWR

404/332-4555 is the number to call for the Centers for Disease Control's Electronic Routing Service for inquiries concerning the Morbidity and Mortality Weekly Report publication. This new telephone feature will allow staff to respond to inquiries relating to MMWR including questions about types and sources of subscriptions, requests for information about published material and questions regarding submitting and scheduling material for publication. Although the routing service is electronic, a caller may elect at any point to request a staff member come on the line to assist him/her.

ROUTINE MEASLES IMMUNIZATION SCHEDULE TO CHANGE

A two-dose measles immunization schedule will soon be recommended by both the American Academy of Pediatrics (AAP) and the Immunization Practices Advisory Committee (ACIP). It is expected the recommendation will have the second dose given at either school entry or prior to a student entering middle school or junior high. For those students who are entering college, who have not had a second dose of measles vaccine and were born after January 1, 1957, the second dose will be given then. MMR will be the vaccine of choice for reimmunization. The Department and the Centers for Disease Control recommend the current recommendations for measles immunization be used. Department-provided vaccine cannot be used for reimmunization at this time. Further information on this topic will be provided to you as it is received from the Centers for Disease Control.

MEASLES CASES ON INCREASE IN U.S. DURING 1989

According to the Centers for Disease Control, there has been a threefold increase in measles cases reported since January 1, 1989 than normally seen (more than 5,000 cases). Eighty-one colleges and universities have been affected. Neighboring states with measles outbreaks at this time include Utah and Washington. Suspected measles cases should be reported immediately to the local health department or the Montana Immunization Program at 444-4740.

WHOOPING COUGH OUTBREAK IN PARK COUNTY

An epidemic of whooping cough (pertussis) has been identified in southern Park County in the Corwin Springs area. The disease has been confirmed through laboratory testing with 20 or more suspected cases occurring during the first two weeks of June. The majority of the cases appear to be in preschoolers.

Volume: 13:6 **Month of:** May, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

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Montana Morbidity Report

VOLUME: 13:7 MONTH OF: JUNE, 1989

Montana State Department of Health and Environmental Sciences

PLEASE RETURN

Lyme Disease

The Montana Department of Health and Environmental Sciences (MDHES) has closely monitored information concerning Lyme Disease in the United States. Montana does have other tick-borne diseases and so the possibility of having Lyme Disease in Montana had to be considered. However, there is no indication endemic Lyme Disease is occurring or has occurred in Montana. There are several factors that lead to this conclusion. The first is related to non-identification of the vector tick in Montana. Lyme Disease is transmitted by several types of ticks but they are not known to live in Montana. During the past year, the Communicable Disease Section of the Preventive Health Services Bureau (PHSB) has investigated, through the cooperation of local health departments, many reports of possible Lyme Disease. In the final analysis, none of these cases have met the Centers for Disease Control (CDC) case definition for Lyme Disease. PHSB is very interested in continuing to hear about probable Lyme Disease cases and proceed with analysis of each case to determine whether or not there is endemic Lyme Disease in Montana. A CDC form is available for detailing information concerning each case and it's very helpful because it guides an investigator to focus on the important aspects of the case definition. Anyone wishing information or further investigation of a possible Lyme Disease case should contact the Communicable Disease Section at 444-4740.

Plague

On Friday, June 23 a cat returned to a family home in Madison County after being absent for four days. The cat was ill and was taken to a veterinarian in Madison County. The veterinarian felt the cat had symptoms consistent with plague and a needle aspirate from a cervical lymph node cultured at a local hospital was reported presumptively positive for Yersinia pestis.

In the past, serosurveys in Montana have indicated there is endemic plague associated with rodents and other wild animals in Montana. In October of 1987 a human case of plague was diagnosed and linked to antelope hunting in the Wheatland County area. Health care providers in Montana need to be aware of the presence of endemic plague in the state. The surveys done in the past did not survey the entire state, but there is reason to believe plague could be endemic in any or all of the counties in Montana.

If plague is suspected in an animal or a human, the persons involved need to be concerned about the likelihood of transmission. Plague is easily transmitted in the pneumonic phase of illness of both animals and humans. Transmission of plague in laboratory settings has been documented and great care should be practiced in handling specimens from possible plague cases. All clinical isolates should be referred to the Montana Public Health Laboratory.

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		1		1											
Blaine		1		3											
Broadwater															
Carbon											3	4			
Carter															
Cascade		16	1	6									1		
Chouteau															
Custer		1													
Daniels															
Dawson		1									1	1	1		
Deer Lodge			2												
Fallon			1												
Fergus	2	2	1									1		1	
Flathead											1		1		
Gallatin		10	1			1					1		1		
Garfield												1			
Glacier		3		1									1	1	
Golden Valley															
Granite															
Hill		6									1				
Jefferson															
Judith Basin												1			
Lake		1													
Lewis & Clark	1	7		1			1				1				
Liberty															
Lincoln		3													
McCone															
Madison	2														
Meagher															
Mineral															
Missoula	2	3	4		1	9	3	1							
Musselshell												2			
Park	1		1												
Petroleum															
Phillips															
Pondera															
Powder River															
Powell		2													
Prairie	1														
Ravalli															
Richland															
Roosevelt		2													
Rosebud		2											1		
Sanders															
Sheridan															
Silver Bow		3													
Stillwater															
Sweet Grass															
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone	1	8	1				2				1	1		1	
MONTHLY TOTAL 19 89	10	74	12	12	1	10	6	1	0	0	9	11	6	3	0
MONTHLY TOTAL 19 88	8	164	20	28	2	0	7	1	0	0	5	15	4	4	5
MONTHLY TOTAL 19 87	6	144	9	60	2	8	3	0	1	2	16	14	6	2	1
TOTAL TO DATE 19 89	29	693	53	106	4	27	25	2	1	1	35	45	29	66	8
TOTAL TO DATE 19 88	23	1050	81	221	6	21	31	7	3	0	33	128	32	44	5
TOTAL TO DATE 19 87	14	737	67	283	11	35	28	7	3	2	58	100	28	13	9

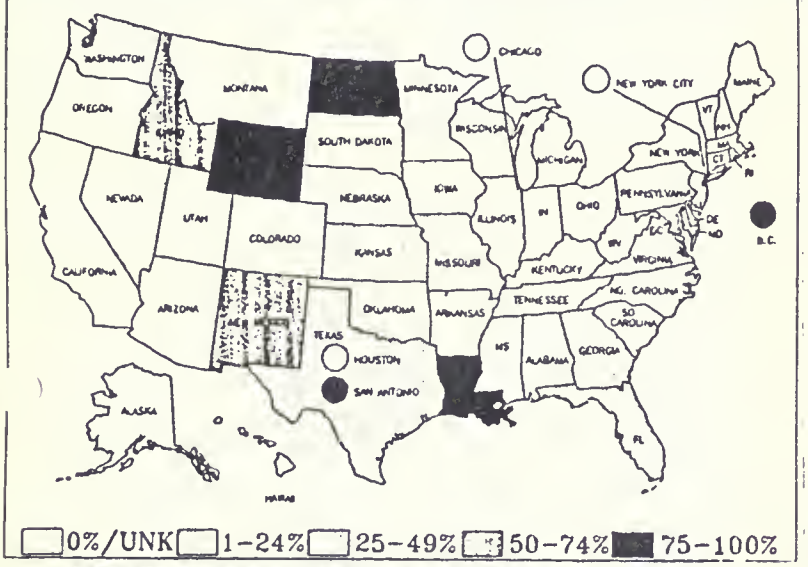
OTHER DISEASES: Aseptic Meningitis: Lewis & Clark, 1; Chickenpox: Cascade, 2; Yellowstone, 4; Colorado Tick Fever: Beaverhead, 1; Missoula, 4; Cytomegalo Viral Illness: Cascade,1; E. Coli0157:H7: Cascade, 1; Flathead, 1; Missoula, 1; Malaria: Gallatin, 1; Pertussis: Park, 10; Rocky Mountain Spotted Fever: Cascade, 2; McCone, 1; Missoula, 2; Ravalli, 1; Wheatland, 1; Q-Fever: Missoula, 1; Early latent Syphilis: Cascade, 1; Yellowstone, 2

Adult Immunization Status: Montana vs. Other States

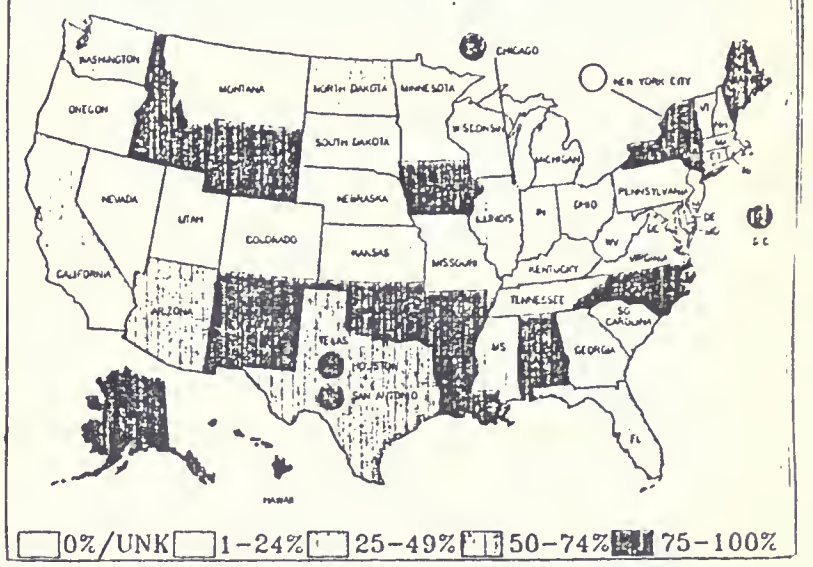
The following graphs show comparisons by state in adult immunization requirements and is based on the most current information made available to state immunization programs. This summary is provided to the Montana Immunization Program each year by the Centers for Disease Control. Hospital, health department and health care employee immunization recommendations, as well as other areas of adult immunization, are available from the Program (444-4740).

DP/war-91xt

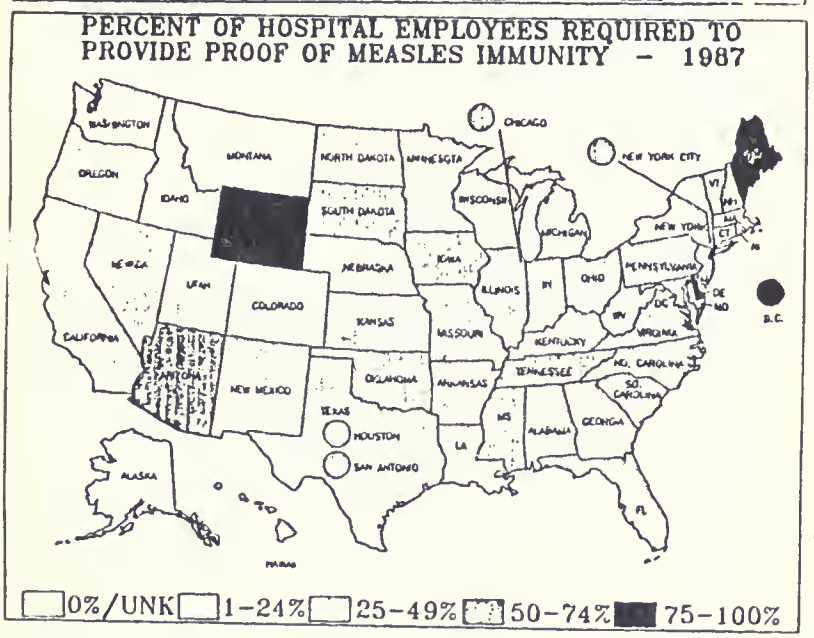
PERCENT OF HEALTH DEPARTMENT EMPLOYEES REQUIRED TO PROVIDE PROOF OF MEASLES IMMUNITY - 1987



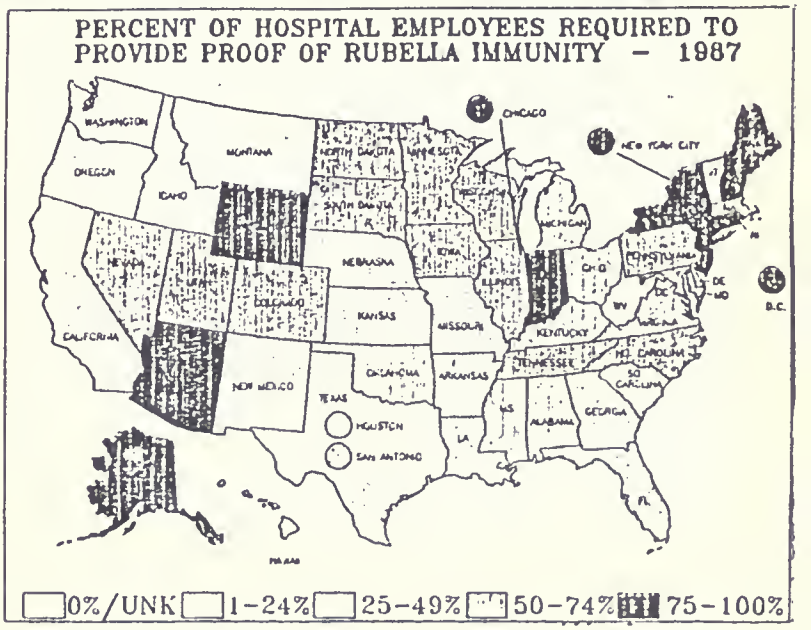
PERCENT OF HEALTH DEPARTMENT EMPLOYEES REQUIRED TO PROVIDE PROOF OF RUBELLA IMMUNITY - 1987



PERCENT OF HOSPITAL EMPLOYEES REQUIRED TO PROVIDE PROOF OF MEASLES IMMUNITY - 1987



PERCENT OF HOSPITAL EMPLOYEES REQUIRED TO PROVIDE PROOF OF RUBELLA IMMUNITY - 1987



* *
* HIV/AIDS INFORMATION *
* *

TREATMENT AND RESEARCH

Guidelines for Prophylaxis Against Pneumocystis carinii Pneumonia for Persons Infected with Human Immunodeficiency Virus (HIV)

Based on preliminary data indicating that a low number of CD4+ (helper) T-cells is a good predictor of the risk of Pneumocystis carinii pneumonia (PCP) and that prophylactic therapy can decrease the risk of recurrent or initial episodes of PCP, the Public Health Service will be recommending the following:

1. HIV infected patients with either prior PCP or less than twenty percent (less than 200/mm3) CD4+ T-cells should receive prophylaxis for PCP.

2. HIV infected patients should be screened for low CD4+ cells at least every 6 months to determine eligibility for PCP prophylaxis.

3. Prophylaxis should consist of either oral trimethoprim/sulfamethoxazole twice daily or aerosolized pentamidine once monthly.

4. Seropositive individuals should be advised of these recommendations and should be assisted in obtaining referral for medical follow-up care, including evaluation of immune function.

HIV counselors should be prepared to include this information in their counseling for seropositive clients. It is likely that these recommendations will increase the demand for counseling and testing services.

(Morbidity and Mortality Weekly Report, June 16, 1989, Vol. 38, No. 5-5)

Human Immunodeficiency Virus Type 1 Infection in Homosexual Men Who Remain Seronegative for Prolonged Periods

A cohort of 133 seronegative homosexual men who continued to be involved in high-risk sexual activity were sampled.

Findings: HIV-1 was isolated in blood samples from 31 of the 133 men (23 percent), 27 of whom have remained seronegative for up to 36 months after the positive culture.

The authors conclude that HIV-1 infection in homosexual men at high risk may occur at least 35 months before antibodies to HIV-1 can be detected.

(Imagawa, David T, Ph.D. et al. N Engl J Med, 6/1/89; 320:1458-62)

The CDC in Atlanta responded to the preceding abstract authored by Imagawa, et al on 6/19/89:

A recent report in the New England Journal of Medicine suggests that up to one-fourth of gay men who engaged in high-risk sexual activity and tested negative for antibodies to human immunodeficiency virus (HIV) may actually be infected with the virus. These findings need to be confirmed by others. Results of similar studies done at the Centers for Disease Control have <u>not</u> been consistent with these findings.

Persons who engaged in high-risk activities in the past, stopped such activities, and were found to be negative for HIV antibodies at least 6 months later do not routinely need to be retested. Persons continuing to engage in high-risk activities should be retested at 3 to 6 month intervals. Other tests for HIV infection, such as virus culture or the polymerase chain reaction, are research techniques and are <u>not</u> recommended for the routine evaluation of antibody-negative persons.

Consensus Statement From Consultation On AIDS And Sports

Sports medicine practitioners, officials of sports organizations and public health professionals are frequently asked about AIDS and sports activities. To provide guidance on these questions, a consultation on AIDS and sports was convened in Geneva on January 16, 1989 by the World Health Organization's Global Programme on AIDS and the Cardiovascular Diseases Unit of the Division of Noncommunicable Diseases. Participants included representatives of the Medical Commission of the International Olympic Committee, the International Federation of Sports Medicine, the International Federation for Wrestling, the International Rugby Football Board and several experts on epidemiological and public health aspects of AIDS.

The consultation developed the following consensus statement:

1. No evidence exists for a risk of transmission of the human immunodeficiency virus (HIV) when infected persons engaging in sports have no bleeding wounds or other skin lesions. There is no documented instance of HIV infection acquired through participation in sports. However, there is a possible very low risk of HIV transmission when one athlete who is infected has a bleeding wound or a skin lesion with exudate and another athlete has a skin lesion or exposed mucous membrane that could possibly serve as a portal of entry for the virus.

2. The possible very low risk of HIV transmission through sports participation would principally involve the combative sports with direct body contact and other sports where bleeding may be expected to occur. In such sports, the following procedures should be considered:

   a. If a skin lesion is observed, it should be immediately cleansed with a suitable antiseptic and securely covered.

   b. If a bleeding wound occurs, the individual's participation should be interrupted until the bleeding has been stopped and the wound is both cleansed with antiseptic and securely covered or occluded.

3. As in other health care settings, for the safety of personnel drawing blood samples from athletes, protective gloves should be worn.

4. Sports organizations, sports clubs and sports groups have special opportunities for additional meaningful AIDS education of athletes, sports officials and ancillary personnel.

   The following should constitute the core of information provided:

   a. HIV can be transmitted through sexual intercourse, blood, and from infected mother to child. Sexual transmission can be either man to woman, woman to man, or man to man, and transmission by blood can include any injection practice in which non-sterile needles and/or syringes are used.

   b. For transmission of HIV through blood to occur during sport, the blood of an infected person must contaminate a lesion/wound or mucous membrane of another person. It should be the responsibility of any athlete participating in a combative sport with direct body contact who has a wound or other skin lesion to report it immediately to a responsible official, and to report for medical attention.

   c. HIV is not transmitted through saliva, sweat, urine, respiratory droplets, handshaking, swimming pool water, communal bath water, toilets, food or drinking water.

5. There is no medical or public health justification for testing or screening for HIV infection prior to participation in sports activities.

6. Persons who know they are HIV infected should seek medical counseling about further participation in sports in order to assess risks to their own health as well as the theoretically possible risk of transmission of HIV to others.

7. Sports organizations, sports clubs and sports groups should be aware of the above recommendations and ensure that all participants, sports officials and ancillary personnel are aware of them. In addition, this may provide the opportunity for reviewing general hygienic practices relating to sports. (World Health Organization (WHO) in collaboration with International Federation of Sports Medicine, Geneva, January 16, 1989.)

TRENDS

AIDS Community-based Care to be Focus of Research Agenda Conference

Large numbers of persons with acquired immunodeficiency syndrome (AIDS) are now being treated at home and through other community-based care programs. Because of the increasing role of non-hospital care and the issues surrounding the care of AIDS patients, the National Center for Health Services Research and Health Care Technology Assessment (NCHSR) has awarded a grant to the University of Minnesota (UM) to organize a special research agenda development conference on the subject. The meeting will be held August 14-15, 1989, at the Raddison University Hotel in Minneapolis, MN. According to Joseph M. Keenan, M.D., Coordinator of Geriatrics and Home Care for UM's School of Medicine and the conference convener, the issues to be discussed include care settings appropriate for the stages of AIDS; the impact on formal and informal caregivers of caring for persons with AIDS; ethics; and research design problems, including cost and financing and severity-of-illness classification.

Federal Government Launches New Phase of "America Responds to AIDS" Public Information Campaign

May 25 was the kick-off of the phase of the federal government's "A Responds to AIDS" public information campaign. The campaign targets parents and youth, and is directed by the federal Centers for Disease Control in Atlanta through the Public Health Service. The main feature of the campaign is a guide to help adults talk with young people about AIDS. Other features of the new campaign include multi-media public service advertising, outreach to local and national organizations, and assistance to state AIDS programs.

RESOURCES

Infection Control Manual for the Dental Office. Katherine West, BSN, MSED, CIC. This manual addresses AIDS, Hepatitis B and other blood-borne disease issues. It contains specific step-by-step procedures to conduct routine operatory procedures and furnishes the rationale for each action. OSHA rules and regulations, staff protection, and immunization recommendations are other topics.
Cost: $85.00/copy.
Make checks payable to:
Infection Control/Emerging Concepts
8631 Tuttle Road
Springfield, VA 22152

The Medical Management of AIDS, edited by Merle Sand and Paul Volberding. A review by Martin Woods appears in The Lancet (05/27/89) Vol. 1, #8648, P. 1169.

This book addresses the problems of doctors working outside of specialist centers who are faced with the medical and emotional complexities of AIDS. Reviewer Martin Wood recommends the book and says it provides most of what there is to know about treating AIDS patients.

Teens Teaching AIDS Prevention (Teens TAP), formed in 1987, is staffed by teen volunteers to assist their peers with advice and accurate information concerning AIDS. Teens TAP avails itself to thousands of teens through a national hotline, the only national toll-free AIDS hotline specifically developed for teens in the U.S. (1-800-234-TEEN). It is staffed Monday through Friday, 4 pm - 8 pm (CST).

Request for Proposal

In mid-August 1989, the United States Conference of Mayors will issue its eighth Request for Proposals (RFP) to fund community based AIDS risk reduction and education programs. The foci of the grants program will be the following:

- o racial and ethnic minority communities including Blacks, Hispanics, Asian/Pacific Islanders and Native Americans;
- o substance users, including intravenous drugs, alcohol and other substances, with an emphasis on direct street outreach programs;
- o HIV antibody positive individuals and people with AIDS; and
- o areas with fewer numbers of AIDS cases.

The primary goal of the RFP is to provide education/information on AIDS and HIV infection through funding non-profit, non-governmental, community based, community service organizations with established ties to the populations they intend to serve. Programs must be new or an expansion of existing activities; they can not be solely a continuation of an existing program. Approximately $1 million will be available to fund 20 one-year, non-renewable programs nationwide. Program funding will range from $20,000 to $50,000 each. Funding for this effort is provided by the federal Centers for Disease Control.

For more information or a copy of the Request for Proposals, please call Matthew Murguia, B.J. Harris or Miriam Phields of the Conference staff at (202) 293-7330.

Overseas. . . .

-- The French military may soon add an additional piece of equipment to the uniform of the typical French soldier. The bright yellow plastic condom-holders would dangle from the belts of French troops if the military approves the idea, which is designed to protect the troops, and those with whom they become sexually involved, from AIDS. Condoms will be sold in every barracks under new military rules, and military medics want to make sure soldiers always have a "preservatif" handy when they are off-base. The condom-holder includes basic instructions on the use of the new equipment, and doubles as a key-holder.

State of Montana
Influenza Vaccine Term Contract

The influenza vaccine for use this fall and winter, 1989, is available to various state offices or agencies through the Montana Department of Administration, Purchasing Bureau. The term contract--TC #199-K -- is in effect to December 31, 1989 but agencies should place their orders by July 31, 1989. The product is Fluzone split or whole, in 5 ml. vials (10 doses) at $17.50/vial. To order, use the above contract number:

Address: E. R. Squibb & Sons
P. O. Box 19618
Irvine, CA 92713-9618
Phone: (800) 854-3050

There will be no delivery prior to September 1, 1989.

Pertussis

Pertussis continues to spread in Park County, as evidenced by laboratory confirmation of 6 more cases. This makes a total of 16 confirmed with many more symptomatic persons. The outbreak still seems contained to the southern half of Park County, though physicians and health departments have been notified to be alert to potential pertussis symptoms in all of Park, Gallatin, Sweet Grass and Stillwater counties. The Preventive Health Services Bureau recommends if families have young children who are not fully immunized with 3-4 pertussis (DTP) immunizations they should not travel through the Corwin Springs area if entering or leaving Yellowstone National Park. For further information call 444-4740.

*MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 06/30/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	20 (45)	11 (55)
Other Disease w/o PCP	21 (48)	14 (67)
KS Alone	3 (7)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	44 (100)	25 (50)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	14 (32)
30-39	19 (43)
40-49	7 (16)
Over 49	4 (9)
Unknown	0 (0)
Total	44 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	40 (91)
Black, Not Hispanic	1 (2)
Hispanic	2 (5)
Other	1 (2)
Unknown	0 (0)
Total	44 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	27 (66)	0 (0)	27 (61)
Intravenous (IV) Drug User	4 (10)	0 (0)	4 (9)
Homo/Bi IV Drug User	5 (12)	0 (0)	5 (11)
Hemophiliac	2 (5)	0 (0)	2 (5)
Heterosexual Contact	0 (0)	3 (100)	3 (7)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (7)	0 (0)	3 (7)
Total	41 (100)	3 (100)	44 (100)

Source: Montana AIDS Program, MDHES, June 30, 1989

*Includes 31 Montana AIDS cases and 13 cases reported to Centers for Disease Control from other states who are living in Montana.

As of June 30, 1989 there have been 205 positive HIV tests from 15,743 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of May 31, 1989, 97,193 cases of AIDS and 56,468 deaths have been reported to the Centers for Disease Control.

Volume: 13:7 **Month of:** JUNE, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

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VOLUME: 13:8 MONTH OF: July, 1989

Montana State Department of Health and Environmental Sciences

1989 STD Treatment Guidelines

The Division of Sexually Transmitted Diseases of the Centers for Disease Control is planning to issue the 1989 STD Treatment Guidelines report as an MMWR supplement this fall. The last report was issued in 1985. Following are some highlights of the forthcoming report:

1. Public Health Guidelines. Rather than focus entirely on treatment recommendations, they have expanded the guidelines to cover an array of screening, education, diagnosis, and treatment services for STD patients; while not in great depth, they will provide a checklist to consider for those interested in STD control.

2. Management of the HIV-Infected Person. Because STD programs are increasingly providing HIV counseling/testing as part of their routine care, our recommendations deal with the appropriate management of the HIV-infected patient in a traditional STD clinic setting. We emphasize that we must go beyond a one-time post-test counseling session to arrange for, and follow-up on, the necessary spectrum of services required for HIV-infected persons.

3. Impact of HIV Infection on STD Clinical Manifestations and Treatment. The immunosuppressive effects of HIV may influence the course of such STD as chancroid, syphilis, and genital herpes. Thus, while they maintain the recommendations for treatments based on peer-reviewed data, they acknowledge other therapy regimens suggested by knowledgeable clinicians.

4. Gonorrhea Therapy. Resistant gonorrhea is an endemic reality in many metropolitan areas. In most situations, they have recommended replacing penicillin with ceftriaxone as a first-line drug for gonorrhea. While this will increase short-term expenses for gonorrhea treatment, in the long run it will prevent extended follow-up of gonorrhea patients, and reduce the level of associated reproductive sequelae. (42/101, or 41.6% of the uncomplicated cases of GC in Montana were treated with either ceftriaxone or spectinomycin during the first 6 months of 1989. 73/103, or 70.9% of GC patients were treated with dual therapy, including doxycycline or tetracycline for a potential coexisting chlamydia.)

5. Syphilis Therapy. Based on previous recommendations to prevent congenital syphilis (MMWR supplement) and on new data addressing treatments for late syphilis and for penicillin-allergic patients, they have updated these guidelines.

6. Doxycycline for Chlamydia. The price of doxycycline is comparable to that of tetracycline in many areas. Because of this, and because of recent evidence that twice-a-day therapy leads to better compliance than four-times-a-day regimens, they are recommending that doxycycline replace tetracycline as the drug of choice for chlamydia.

PLEASE RETURN

JULY 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal diseases	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2									1				
Big Horn		5		2											1
Blaine		1													
Broadwater															
Carbon		1										2			
Carter															
Cascade		14		1			1					2			
Chouteau															
Custer		2													
Daniels															
Dawson											2				
Deer Lodge		1													
Fallon															
Fergus											4	2	1		
Flathead		4				1		1			2	1			
Gallatin	3	11	1								2				
Garfield															
Glacier	1	7												2	
Golden Valley															
Granite			1												
Hill		4				2									
Jefferson															
Judith Basin															
Lake		5													
Lewis & Clark		15	1	5		2	6				2		1		
Liberty															
Lincoln															
McCone															
Madison	1														
Meagher					1										
Mineral															
Missoula	5	7	1			2									
Musselshell											1				
Park														1	
Petroleum															
Phillips		1													
Pondera	1														
Powder River															
Powell		1													
Prairie															
Ravalli		1	2								1	1			
Richland				1											
Roosevelt		3		2											1
Rosebud		3		2								1			1
Sanders															
Sheridan															
Silver Bow		1											1		
Stillwater		1													
Sweet Grass															
Teton			10												
Toole															
Treasure															
Valley	1	2													1
Wheatland															
Wibaux															
Yellowstone	5	18	2	1			1		1			1	4		
MONTHLY TOTAL 1989	17	110	18	14	1	7	8	1	1	0	15	10	7	3	4
MONTHLY TOTAL 1988	17	141	19	41	0	4	2	1	0	1	14	15	12	47	0
MONTHLY TOTAL 1987	6	176	12	60	0	14	6	0	0	1	14	9	5	3	0
TOTAL TO DATE 1989	46	803	71	120	5	34	33	3	2	1	50	55	36	69	12
TOTAL TO DATE 1988	40	1191	100	262	6	25	33	8	3	1	47	143	44	91	5
TOTAL TO DATE 1987	20	913	79	343	11	49	34	7	3	3	72	67	33	16	9

OTHER DISEASES: Amebiasis: Cascade, 1; Brucellosis: Deer Lodge, 1; Chickenpox: Cascade, 3; Gallatin, 2; Colorado Tick Fever: Beaverhead, 1; Big Horn, 1; Missoula, 1; Yellowstone, 1; Cytomegalo Viral Illness: Cascade, 1; Pertussis: Flathead, 1; Park, 10; Q-Fever: Powder River, 1; Rocky Mountain Spotted Fever: Lewis & Clark, 1; Ravalli, 1

* *
* HIV/AIDS INFORMATION *
* *

TREATMENT AND RESEARCH

The Food and Drug Administration approved the drug ganciclovir to treat an eye infection, cytomegalovirus retinitis, that can sometimes lead to blindness in AIDS and other immune-suppressed patients.

FDA said that the drug, which is also known as DHPG, slows the progression of cytomegalovirus (CMV) retinitis -- an eye condition caused by an opportunistic infection affecting about one in every four AIDS patients, and some other patients with reduced immune functions, such as organ transplant recipients.

HHS Secretary Louis W. Sullivan, M.D., said, "This and other recent developments in AIDS treatment demonstrate a commitment by HHS and its component FDA to speed the availability of AIDS-related drugs."

The approval was based on several studies of ganciclovir's use as a short-term therapy, but Dr. Sullivan and FDA Commissioner Frank E. Young, M.D., Ph.D., said that much remains to be learned about the drug's effects.

"To answer these questions," Dr. Young said, "the approval of ganciclovir will be accompanied by extensive post-marketing studies to explore more fully the drug's benefits and limitations, especially its role in use with AIDS therapies such as zidovudine, or AZT."

The recommended treatment with ganciclovir consists of intravenous infusions twice a day for two to three weeks, followed indefinitely by a maintenance therapy of infusions once a day.

Syntex Corp. of Palo Alto, CA, will market the drug under the trade name Cytovene.

Ganciclovir has been available to some patients through a Treatment IND program sponsored by the National Institute of Allergy and Infectious Diseases and through other protocols sponsored jointly by NIAID and Syntex. The program allows patients with serious or life-threatening conditions to get pre-approval access to experimental drugs that have shown significant promise.

Although ganciclovir may slow the progression of CMV retinitis in immunocompromised patients, it is not a cure for the disease and not all patients respond to it. About 40 percent of all AIDS CMV retinitis patients may be unable to tolerate ganciclovir treatment because of the adverse affects it has on the production of critical blood cells. Preliminary data also suggest that ganciclovir may not be tolerated well in conjunction with therapies for AIDS and other AIDS-related conditions when administered at the same time.

Ganciclovir was first synthesized in the early 1980's and developed as a potential therapy against the herpes simplex virus. By 1983, further laboratory studies by Syntex indicated that the drug might be effective against other viruses, including cytomegalovirus.

From Heinz G. Wilms, Director, Division of Federal-State Relations, ORO/FDA.

Expanded Pre-Market Distribution of New Drug

HHS Secretary Louis W. Sullivan, M.D., announced that the Food and Drug Administration is permitting expanded pre-market distribution of an experimental protein product to treat the severe anemia that weakens nearly half the 20,000 patients currently taking zidovudine, commonly known as AZT, for AIDS. The drug will also be made available to the smaller number of AIDS patients suffering from anemia related to the disease itself.

In the past, the severe anemia associated with AZT and AIDS has required repeated blood transfusions. In some cases, AZT has had to be discontinued.

The protein product, r-erythropoietin, is a form of a protein formed in the kidneys, erythropoietin, which stimulates the body's production of red blood cells. Scientists are able to make quantities of

the protein for treatment through gene-splicing techniques.

FDA Commissioner Frank E. Young, M.D., Ph.D., said, "This new biotech product should improve the quality of life for those whose lives depend upon zidovudine. Its pre-market release -- the fourth for AIDS-related products -- reaffirms HHS' and FDA's commitment to providing people with life-threatening and serious diseases the earliest possible access to promising treatments." FDA is part of the Public Health Service within HHS.

In controlled clinical studies involving more than 100 AIDS patients who had experienced severe anemia from zidovudine, r-erythropoietin appeared to restimulate the production of red blood cells and reduce or eliminate the need for transfusions.

The data from this study served as the basis for granting today's "treatment IND" status. (IND stands for investigational new drug.) This status allows patients suffering from serious or life-threatening conditions to get pre-approval access to experimental drugs that have shown significant promise.

Under this treatment IND protocol, AZT patients and other AIDS patients who have experienced severe anemia will be eligible to receive r-erythropoietin treatment. The product will initially be in limited supply but its availability will be expanded during the next several weeks.

Ortho Pharmaceutical Corp. of Raritan, NJ, will sponsor the treatment IND protocol. The company has also filed a product license application for r-erythropoietin which FDA is currently reviewing.

Physicians interested in the details of this treatment IND protocol can contact an Ortho hotline at (800) 243-7739.

From Heinz G. Wilms, Director, Division of Federal-State Relations, ORO/FDA.

FDA Statement on Unauthorized AIDS Drug Study

In the past few days there have been several media reports of a death associated with an unauthorized use of trichosanthin, a plant derivative commonly called "Compound Q," in people with AIDS. The following information can be used to answer questions:

Trichosanthin is a plant protein, which researchers think may be an effective agent against the AIDS virus. An FDA-sanctioned clinical study of GLQ-223, a refined form of trichosanthin, was started at San Francisco General Hospital in May 1989. This initial human study is designed to test the safety of this drug's use in treating AIDS patients, and particularly to determine at what dose levels the drug can be tolerated.

According to media reports, Project Inform, a San Francisco-based AIDS activist group initiated distribution of a trichosanthin-based preparation imported from China, supposedly to test its efficacy in AIDS patients. Project Inform undertook this operation without an FDA sanction or approval, and has apparently been conducting it for a number of months. There have been several media reports that the death of one patient and the serious adverse reactions of other patients participating in this informal study have been either directly or indirectly linked to this trichosanthin-based product.

FDA is conducting an investigation of the Project Inform operation. The scale and nature of the Project Inform operation are largely unknown to the agency. The safety procedures in this study are not known and the exact circumstances surrounding the death and other adverse reactions reported to have occurred in this trial have not been ascertained. Questions also remain about the exact composition of the product and whether it was illegally imported into the country.

The agency feels that the concerns raised by this operation point out the need to conduct clinical studies in a scientific manner, that includes careful study

design, institutional monitoring mechanisms and consistent reporting channels. Such studies assure the acquisition of good clinical data in the shortest possible time, and ensure the safety of patients.

From Heinz G. Wilms, Director, Division of Federal-State Relations, ORO/FDA.

FDA Issues Warning

The Food and Drug Administration (FDA) sent out a warning April 13 that industrial strength hydrogen peroxide illegally promoted to treat AIDS and cancer has caused at least one death in Texas and several injuries requiring hospitalization. The products are sold as "35% Food Grade Hydrogen Peroxide" to be used in "Hyperoxygenation Therapy" for AIDS, cancer, and more than 60 other conditions. FDA said there is no proof that either the product or the therapy has any medicinal value. Further, the 35% concentration is highly corrosive. FDA considers it dangerous even if handled according to the manufacturer's directions. the products-- sometimes called "Biowater" and H2O2"-- are promoted as "alternative medicine" by mail-order distributors and by some health food outlets.

Contact Mike Shaffer, FDA (301) 443-3285.

Additional Pentamide Information

A 300 mg dose of NebuPent (TM) (nebulized pentamidine) administered every four weeks using a Respirgard (TM) II nebulizer has been shown to be effective and safe in preventing PCP (Pneumocystis Carinii pneumonia), the leading cause of death among those with AIDS.

On June 15th, the FDA gave official, full marketing approval to NebuPent (TM), which is manufactured and marketed exclusively by Lympomed, Inc. The medical profession has been handed a powerful tool to supplement its otherwise meager arsenal in the battle against HIV.

Full approval also means more comprehensive insurance reimbursement of NebuPent (TM) prophylaxis -- which is overwhelmingly cost-effective when compared to the cost of in-patient treatment for an acute episode of PCP.

Lyphomed's national toll-free NebuPent (TM) Information Line (1-800-PCP-7003) will be retained to provide answers to patients and their physicians concerning the prevention of PCP with NebuPent (TM).

Lyphomed will conduct several Phase IV (post-approval) clinical trials -- to further refine the dosage regimen, to test other delivery systems, and to determine the effectiveness and safety of NebuPent (TM) in different patient populations (children, IV drug users, women).

Lyphomed is in the final stages of designing an indigent patient program that will provide, through community-based organizations, free drug to those who need it but cannot afford it.

For questions concerning NebuPent (TM)-- its availability, administration, side effects, labeled uses, patient profile, etc., please call 1-800-888-7704, extension 1772.

Richard White, Product Manager, Lyphomed, Inc.

Use of Polymerase Chain Reaction for Early Detection of the Proviral Sequences of Human Immunodeficiency Virus in Infants Born to Seropositive Mothers

Abstract: In a new study, Rogers et al., report they used the polymerase chain reaction (PCR) to amplify proviral sequences of HIV within the DNA of infants born to seropositive mothers. PCR detected HIV infection in five of seven infants who later developed AIDS, in one of eight newborns with nonspecific signs and symptoms suggestive of HIV, and in all of six postneonates who later had AIDS. The researchers conclude that PCR will be a useful technique in the diagnosis and prediction of development of AIDS, but that more studies are needed to fine-tune the test.

(Rogers, Martha F., et al. N Engl J Med, 6/22/89; 320:25, P 2549.)

LEGAL ISSUES

AIDS Infection Viewed as Toxin Exposure

The Appellate Division of the New York State Supreme Court has ruled that Veronica Prego, a New York doctor who has AIDS, may continue a $750 million suit against the City of New York and Kings County Hospital Center in Brooklyn. According to Prego, she became infected with HIV in late 1982 or early 1983 when she was working at the hospital. She alleges that a contaminated needle left by a Kings County Hospital staff physician on the bed of an AIDS patient stuck her. The city said she failed to file the personal injury claim within the one-year-plus-90-days statutory deadline. Prego, who filed the suit last year, said she did not learn she was infected until 1985. She developed AIDS in late 1987. The court relied on the 1986 New York state statute that permits persons alleging injury from exposure to a toxic substance to file claims after the usual deadline.

(Insight (06/26/89) Vol. 5, No. 26, P. 52) Powell, Monica

TRANSMISSION

Substance Abuse and HIV/AIDS

TACOMA NEEDLE EXCHANGE, WASHINGTON STATE

The Tacoma Needle Exchange (TNE), begun in August 1988 through the efforts of Dave Purchase, has been operated since January 1989 by the Tacoma-Pierce County Health Department.

TNE employs two strategies: 1) for those who have not begun injecting and those who wish to quit -- provide education and increase access to treatment, and 2) for those who can't stop or want to continue-- provide risk reduction education, i.e., bleach and teach the needle exchange. Street support is provided by AIDS prevention outreach workers who offer coupons for low-cost drug treatment and HIV education.

In response to the argument that needle exchange sanctions drug use, TNE points to the absence of scientific evidence that the decision to inject drugs is based on the availability of clean needles. New York City, with over a quarter million addicts, has strict needle access laws. Further, a consistent finding of the Amsterdam needle exchange program has been a doubling of the number of IVDAs entering treatment.

Critics also charge that needle exchange results in an increase of carelessly discarded needles and syringes. However, TNE reports the built-in incentive of an exchange has resulted in fewer community calls reporting problems of discarded works in public places.

Locally, TNE has been well-supported. A survey conducted by the largest local newspaper found two-thirds of the general public in favor of needle exchanges. Additional support has been provided in editorials by three other major newspapers.

Data from a pilot survey of 66 TNE participants offered these breakdowns: mean age is 32; injecting history of the majority was 5 years or more; 43% are female; over half are non-white; 90% reported not sharing, or sharing but using bleach (compared to 60% prior to TNE); and 92% inject just as often or less often since using the TNE.

From AMA, Department of Substance Abuse, Bonnie Wilford, Director.

RESOURCES

AIDS, Sexual Behavior, and IV Drug Use, a comprehensive report addressing the behavioral aspects of the AIDS epidemic, is available from the National Academy Press, 2101 Constitution Avenue, NW, Washington, DC 20418. 589 pp. $24,95.

The Children With AIDS Newsletter is available from the Foundation for Children with AIDS, 77B Warren St., Brighton, MA 02135 (615) 783-7300. $15.00

The risk of HIV transmission by blood transfusion is variously estimated to be from 1:40,000 to 1:1,000,000, according to the NIH report from the Consensus Development Conference on Perioperative Red Cell

Transfusion. For a free copy of the report, write to the Office of Medical Applications of Research, ATTN: Michael J. Berstein, Bldg. 1, Room 260, National Institutes of Health, Bethesda, MD 20892.

The Children's Defense Fund (CDF) has issued a new report entitled Teens and AIDS: Opportunities for Prevention. $4.50. CDF, 122 C Street, NW, Washington, DC 20001 (202) 628-8787.

Robert Wood Johnson Grant Guide available free. Write RWJ Foundation, Box 2613, Princeton, NJ 08543-2326.

The American Red Cross, in cooperation with the Centers for Disease Control, has released seven new and more explicit brochures, which are now available free from local chapters. The new titles are: Your Job and AIDS: Are There Risks?; Men, Sex and AIDS: Women, Sex and AIDS; Drugs, Sex and AIDS; Children, Parents, and AIDS: Information for Teachers and School Officials; and Teenagers and AIDS.

AIDS Foundation Houston (AFH) has produced two new 30-minute video tapes for minorities. "Unidos Contra el Sida," and "AIDS: It's a Black Problem, Too." Contact AFH, 3927 Essex Lane, Houston, TX 77027 (713) 623-6796.

The National Institute of Allergy and Infectious Diseases (NIAID) has established a NIAID AIDS Clinical Trials Information Service. The computerized service provides current information, free of charge, about clinical trials sponsored by the National Institutes of Health (NIH) for AIDS patients and others infected with the human immunodeficiency virus (HIV).

Callers may reach the service by dialing 1-800-TRIALS-A, Monday through Friday between 9:00 a.m. and 7:00 p.m., e.d.t.

Seattle-King County Chapter Develops New Video for AIDS Caregivers

A video addressing issues faced by people with AIDS (PWAs) and their caregivers has been developed by the Seattle-King County Chapter. Entitled, "Finding Our Way Together: People With AIDS and Their Caregivers," the 30-minute work shows PWAs from a wide range of ethnic and cultural backgrounds as they interact with their caregivers. The caregivers themselves also relate the challenges and rewards of their situations. The video is part of the Seattle Chapter's on-going efforts to provide care for the caregiver. A related project is the "Helping You Care" course. The video will be shown at the 5th annual conference on AIDS in Montreal. Copies cost $40. For more information contact:

Laurel Bennett, Paul Mueller or
Hope Tuttle
Seattle-King County Chapter
American Red Cross
AIDS Education Department
1900 25th Avenue South
Seattle, WA 98144-4708
Phone: (206) 323-2345

CONFERENCES

The Management of Medical and Infectious Waste: Practical Considerations
Sponsored by Hazardous Materials Control Research Institute (HMCRI)

This 2-day conference will focus on issues surrounding medical and infectious waste management including future EPA requirements, impact on small and large generators, current and pending federal regulations and cost-effective methods and technologies for handling and disposing of medical and infectious waste. For more information contact:

HMCRI-IW
9300 Columbia Blvd.
Silver Spring, MD 20910-1702
Phone: (301) 587-9390

CLASS OFFERING

The Montana Department of Health and Environmental Sciences, AIDS Program, announces a date for the next HIV Counselor Course. The course will be offered September 13 and 14 in Helena. This course is being offered to provide training for people involved in counseling persons who request the HIV test. For more information call Andrea Baumgardner or Cathy Silva at 444-4740.

***MONTANA**
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 07/31/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	21 (46)	11 (52)
Other Disease w/o PCP	22 (48)	14 (64)
KS Alone	3 (7)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	46 (100)	25 (54)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	14 (30)
30-39	21 (46)
40-49	7 (15)
Over 49	4 (9)
Unknown	0 (0)
Total	44 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	42 (91)
Black, Not Hispanic	1 (2)
Hispanic	2 (4)
Other	1 (2)
Unknown	0 (0)
Total	44 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	28 (65)	0 (0)	28 (61)
Intravenous (IV) Drug User	4 (9)	0 (0)	4 (9)
Homo/Bi IV Drug User	5 (12)	0 (0)	5 (11)
Hemophiliac	2 (5)	0 (0)	2 (5)
Heterosexual Contact	0 (0)	3 (100)	3 (7)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	4 (9)	0 (0)	4 (9)
Total	41 (100)	3 (100)	44 (100)

Source: Montana AIDS Program, MDHES, July 31, 1989

*Includes 32 Montana AIDS cases and 14 cases reported to Centers for Disease Control from other states who are living in Montana.

As of July 31, 1989 there have been 208 positive HIV tests from 16,113 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of June 30, 1989, 99,936 cases of AIDS and 56,468 deaths have been reported to the Centers for Disease Control.

DK/war-xt
aug-morb.aid
ged

Tuberculosis Video Tape

The Preventive Health Services Bureau has received a video tape made by the American Lung Association of Virginia entitled, "Treating People with Tuberculosis." The video tape is approximately 20 minutes in length and is designed to give information to people recently diagnosed with tuberculosis. It would also be appropriate for general audiences interested in knowing more about tuberculosis and the family members and contacts of a newly diagnosed tuberculosis case. The video tape is done in a question and answer format with a physician being asked questions about medical treatment by a nurse and then the physician asking the nurse questions about social, economic and everyday living factors related to tuberculosis. If you are interested in using this video tape, please contact the Communicable Disease Section at 444-4740.

Measles Outbreak Reports Now Available

Persons who would like a copy of the measles outbreak reports for the following should contact the Montana Immunization Program at 444-4740:

-- Great Falls - 1987
-- Yellowstone County - 1987
-- Havre - 1987
-- Statewide Outbreak - 1987
-- Park County Outbreak - 1988
-- Flathead County - 1989 (being brought to completion)

Notice to Montana Morbidity Report Subscribers

We are in the process of updating our mailing list. If you are receiving duplicate copies, or have a name or address change, please inform us. Also, if you know of anyone wishing to receive a copy of this publication, have them contact us at:

MDHES
Montana Morbidity Report
Communicable Disease Section
Cogswell Building - Room C-303
Helena, MT 59620

Volume: 13:8 **Month of:** July, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

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Montana Morbidity Report

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VOLUME: 13:9 MONTH OF: August, 1989

Montana State Department of Health and Environmental Sciences

The following are summaries comparing 1988 and 1989 immunization levels in school enterers (K or 1), K-12 students and Licensed Day Care Centers by vaccine type. These summaries are based upon surveys done by the Montana Immunization Program.

Ninety-five (71%) of the 133 day care centers reported immunization information. The results of 5,821 children surveyed at the 95 centers are as follows:

Immunization Levels by Vaccine Type in Licensed Day Care Centers 1988 and 1989, Montana

Vaccine Category	Percent Immunized 1987-88	1988-89
Polio (3+ Doses)	89%	89%
DTP (3+ Doses)	92%	89%
Measles Vaccine	91%	89%
Rubella Vaccine	90%	89%
Mumps Vaccine	90%	89%
Combinations		
P(3+), D(3+), M, R	90%	88%
P(3+), D(3+), M, R, Mumps	89%	88%

Eighty-eight percent of those attending licensed day care in 1989 were fully immunized in January 1989.

The K-12 survey and follow-up was completed in April. The results of 24,474 students (18% of the school population) are as follows:

Immunization Levels by Vaccine Type in K-12 School Attendees 1988 and 1989, Montana

Vaccine Category	Percent Immunized 1987-1988 School Year Results	1988-1989 School Year Results
Polio (3+ Doses)	98%	98%
DTP/Td (3+ Doses)	98%	98%
Measles Vaccine	98%	98%
Rubella Vaccine	98%	98%
Mumps Vaccine*	95%	97%
Combinations		
P(3+), D(3+), M, R	97%	98%

*MUMPS reporting was not required at the time of the survey. Percent given is for schools who voluntarily reported.

Ninety-eight percent of K-12 attendees were fully immunized for the school year 1988-89.

The K-1 school enterers survey was conducted during December 1988 - January 1989 for the school year 1988-89. The results of 12,684 students surveyed are as follows:

Immunization Levels by Vaccine Type in School Enterers 1988 and 1989, Montana

Vaccine Category	Percent Immunized 1987-1988 School Year Results	1988-1989 School Year Results
Polio (3+ Doses)	96%	97%
DTP/Td (3+ Doses)	96%	97%
Measles Vaccine	98%	98%
Rubella Vaccine	98%	98%
Mumps Vaccine*	98%	98%
Combinations		
P(3+), D(3+), M, R	96%	97%

*MUMPS reporting was not required at the time of the survey. Percent given is for schools who voluntarily reported.

Ninety-seven percent of new school enterers were fully immunized for the school year 1988-89.

For more information, contact the Montana Immunization Program at (406) 444-4740.

PLEASE RETURN

AUGUST 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		2				1								1	
Blaine		1	1												
Broadwater															
Carbon											2	1			
Carter															
Cascade		10	1	3							1		1		
Chouteau		1	2												
Custer		4													
Daniels															
Dawson		1									1	1	1		
Deer Lodge	1	2	1												
Fallon															
Fergus	1		2								2				
Flathead	3	10	2	4			1	1			1		3		
Gallatin		5		1		2							1		
Garfield															
Glacier	1	9	1											2	
Golden Valley															
Granite															
Hill		4	1			1									
Jefferson															
Judith Basin															
Lake	1	3	1		1	2	1				1				
Lewis & Clark	2	10	1			1							4		
Liberty															
Lincoln	3	4	1												
McCone															
Madison		1												1	
Meagher				1											
Mineral															
Missoula		4	2			4	2				1				
Musselshell												1			
Park															
Petroleum	1														
Phillips															
Pondera			1												
Powder River															
Powell		1		1											
Prairie															
Ravalli															
Richland															
Roosevelt		4	1	2							4				
Rosebud		1		1							2				
Sanders															
Sheridan															
Silver Bow	4	9	3	2	1						1		1		
Stillwater		1	1												
Sweet Grass	2	2													
Teton			2												
Toole												2			
Treasure															
Valley		1													
Wheatland															
Wibaux	1	1													
Yellowstone	1	11		4				1			1	2			
MONTHLY TOTAL 1989	21	104	24	19	2	11	4	2	0	0	17	7	11	4	0
MONTHLY TOTAL 1988	10	170	21	27	1	1	5	1	0	0	9	17	18	36	7
MONTHLY TOTAL 1987	7	201	11	60	0	14	3	2	0	0	8	15	16	4	0
TOTAL TO DATE 1989	67	907	95	139	7	45	37	5	2	1	67	62	47	73	12
TOTAL TO DATE 1988	50	1361	120	289	7	26	37	9	3	1	56	160	61	127	12
TOTAL TO DATE 1987	27	1114	90	403	11	63	37	9	3	3	79	82	49	20	9

OTHER DISEASES: Amebiasis: Gallatin, 1; Aseptic Meningitis: Flathead, 1; Valley, 1; Chickenpox: Cascade, 6; Silver Bow, 7; Colorado Tick Fever: Gallatin, 1; Park, 1; Cytomegalo Viral Illness: Cascade, 1; Custer, 1; Missoula, 1; E.Coli0157:H7: Lewis & Clark, 1; Missoula, 1; Pertussis: Gallatin, 2; Park, 5; Yellowstone, 1; Rocky Mountain Spotted Fever: Dawson, 1; Ravalli, 1; Tuleremia: Big Horn, 1

* *
* HIV/AIDS INFORMATION *
* *

TREATMENT AND RESEARCH

New AIDS Test Detects Antigens

On August 4, the FDA approved and licensed the 1st diagnostic kit to detect HIV-1 by directly detecting the proteins, or antigens of the virus rather than antibodies that have developed in response to HIV-1 infection.

The HIV-1 antigen test kit may help physicians monitor changes in the medical condition of HIV-1 infected people. This knowledge can help the physician and patient determine whether the HIV-1 infected patient might be progressing to a more advanced state of disease and what type of therapy should be initiated. It is not recommended for use in screening blood or plasma donations.

Abbott Laboratories of Abbott Park, IL, the developer of this HIV-1 antigen test kit, will market this newly licensed test for use as a diagnostic/prognostic test under the trade name HIVAG-1.

For further information please contact MDHES AIDS/STD Program, 444-4740.

HIV, Infection of Newborns

Successful neonatal intervention and treatment of infections with HIV depend on defining the pathogenesis of infection, according to Samuel Katz and Catherine Wilfert of the Duke University School of Medicine. Because studies to date have focused on epidemiology and clinical observations, the time of infection, whether in utero or intrapartum, is unknown. Children with AIDS represent only 2 percent of the total number of AIDS cases. However, the number of pediatric AIDS cases is expected to rise with the increased HIV infection rates of women of childbearing age. HIV infection in newborns is difficult to identify, progresses very rapidly, and severely compromises immature, developing functions. Early therapeutic or preventative measures immediately after birth offer the only hope for combatting this lethal infection. Katz and Wilfert write that polymerase chain reaction studies show promise of detecting neonatal HIV infection for immediate therapeutic intervention and may guide studies to prevent transmission.

New England Journal of Medicine (06/22/89) Vol. 32, No. 25, P. 1687 (Katz, Samuel L., and Wilfert, Catherine)

HIV Infection Associated With Injections of Anabolic Steroids

Michael J. Scott and Michael J. Scott, Jr. of the U.S. Table Tennis Association report a case of HIV transmission by intramuscular injection of anabolic steroids. A 26-year-old white male bodybuilder shared an unsterilized hypodermic needle to inject black market steroids on about 60 occasions with a friend whom the man later learned had developed AIDS. The concerned man asked to be tested and was found to be seropositive. The needle-sharing appears to be the means of infection because the man had no history of risk behavior other than the needle sharing.

Journal of the American Medical Association (07/14/89) Vol. 262, No. 2, P. 207 (Scott, Michael J.)

Dipyridamole May Enhance Effectiveness of AIDS Therapy

Scientists at the National Institutes of Health (NIH) have discovered that the drug dipyridamole (Persantine) enhances the effects of AZT and dideoxycytidine in human monocyte/macrophages, according to James Wyngaarden, Director of NIH. The researchers found that dipyridamole decreased the 50 percent inhibitory dose values of AZT and dideoxycytidine in HIV-infected peripheral blood monocytes. In addition, dipyridamole--a platelet anti-aggregant and coronary vasodilator--did not increase AZT's toxic effects on bone marrow cells. However, Wyngaarden warns, these in vitro studies cannot predict safety or efficacy of dipyridamole before clinical trials.

Journal of the American Medical Association (07/07/89) Vol. 262, No. 1, P. 17 (Wyngaarden, James B.)

TRENDS

Youth Against AIDS Day

August 14, 1989 was Youth Against AIDS Day for the Crow Reservation in Crow Agency, Montana. Events included runs, games, videos and discussions, as well as the storytelling of the Old Man Coyote Story focusing on knowing who you enter into a relationship with. T-shirts were designed with the words "Protect Us" written in Crow language at the top. The community also donated door prizes for a drawing, including a mountain bike, stereo and portable TV. The event was sponsored by grant monies made available to the MDHES by CDC and administered through the Montana United Indian Association.

"Prevention and Beyond"

Was the title of the 3rd National Conference on HIV and AIDS among racial and ethnic populations held in Washington, D.C., August 14-18, 1989 and attended by over 3000 people. The keynote speaker was the recently appointed Secretary of Health and Human Services, Lewis W. Sullivan, M.D. Present from the State of Montana were: Debbie Tatsey and Joann Youngbear from the Native American Service Agency, Patricia Boggs from North American Indian Alliance, Connie MacKay from Great Falls Native American Center and Donna Kotyk from MDHES.

AIDS Panel Filled Out

Belinda Ann Mason, a Kentucky woman is one of President Bush's final two appointees to the National AIDS Commission Congress created last November, and the only one with AIDS. Mason, a former journalist and mother of two who contracted AIDS from a tainted blood transfusion during the birth of her second child, is President of the National Association of People with AIDS. She also educates people about "the human side of AIDS." Belinda has tentatively accepted an invitation to the Montana Conference on AIDS II scheduled for March 22-23, 1990 in Bozeman.

Health Hints for the International Traveler--AIDS and HIV Infection

In the United States, Australia, Canada, Japan and western European countries, there is mandatory testing of all donated blood for the presence of antibodies to HIV.

In other countries, especially less-developed nations, there may or may not be a formal testing program for testing blood or biological products for antibody to HIV. In these countries, use of locally-produced blood clotting factor concentrates should be avoided. If transfusion is necessary, the blood should be tested, if at all possible, for HIV antibodies by appropriately-trained laboratory technicians using a reliable test. Needles used to draw blood or administer injections should be sterile, preferably disposable, and pre-packaged in a sealed, single unit container. Diabetics or other persons who require routine or frequent injections should carry a supply of syringes and needles sufficient to last their entire stay aborad.

International travelers should also be aware that some countries have recently established a policy to serologically screen incoming travelers (primarily those with extended visits) and to exclude persons with AIDS and those whose serum tests positive for HIV antibody. Persons intending to visit a country for a prolonged period should be informed of the policies of the particular country.

Centers for Disease Control. Health Information for International Travel 1988. HHS Publication No. (CDC) 88-8280.

Overview of 1989 Legislation

By June of 1989, 48 state legislatures had proposed more than 500 AIDS-related bills; 23 states had passed 45 new AIDS-related laws. More than 360 AIDS laws have been passed since 1983. The two major types of legislation debated were attempts to address AIDS policy issues and

attempts to modify or refine existing policies or programs. Laws focused on issues of testing, confidentiality, disclosure, discrimination, disease control, financing, and health care.

Intergovernmental AIDS reports (06/89) Vol. 2, No. 9, P. 1.

RESOURCES

The Quilt

The NAMES Project AIDS Memorial Quilt is known around the world as a symbol of the humanity behind the AIDS epidemic statistics. Made up on individual 3' x 6' panels, each memorializing a person who has died of AIDS, the Quilt is an example of the loving and compassionate response of which each of us is capable.

Total weight	16 tons
No. of 3'x6' panels:	8,920

For information on how to create a memorial panel, please contact MDHES at 444-4740, or, The NAMES Project, P.O. Box 14573, San Francisco, CA 94114.

4th National Forum on AIDS and Hepatitis B: Nov. 19-21, 1989, The Washington Hilton, Washington, D.C. Sponsored by the National Foundation of Infectious Diseases, c/o ASM Meetings, 1913 Eye Street, Northwest, Washington, D.C. 20006 (202) 833-9680.

"AIDS Prevention Guide": An information kit developed by CDC and designed to help parents and other adults (such as counselors, coaches, and relatives) to have AIDS prevention conversations with young people. This kit can be ordered, free-of-charge, from the National AIDS Information Clearinghouse (1-800-458-5231).

Talk Listen Care Kit: Developed by the Harvard Community Health Plan Foundation. (The kit, which costs $9.95, can be ordered by calling 1-800-TLC-KITT.) It offers two books, one a guide to help parents of pre-teens talk about sex and the other for younger children. There is also a card game for ages 9 and up about subjects ranging from messy rooms and divorce to contraception and AIDS, and a quiz for parents that troubleshoots common problems of discussing sex with kids.

AIDS in Sport: Booklet, 1989, 27 pp. This publication is a resource for health educators to give to coaches or others who come in contact with athletes. American Coaching Effectiveness Program National Center, Box 5076, Champaign, IL 61820; (800) 342-5457. In Illinois (800) 334-3665. Price: $1.00 each. Quantity discounts available.

1-800-TRIALS-A: A listing for experimental treatments for AIDS and AIDS-related conditions Monday through Friday, 9 a.m. to 7 p.m. EST.

NEW CLASSIFICATION FOR TUBERCULOSIS SKIN TEST REACTORS

MDHES recently received the following information from the Centers for Disease Control. Reactions to the intracutaneous Mantoux test (5 TU PPD) should now be interpreted as follows: A reaction of five millimeters or more of induration is classified as positive in the following groups: 1) persons who have had close recent contact with tuberculosis; 2) persons who have chest radiographs consistent with tuberculosis; and 3) immununosuppressed persons. A reaction of ten millimeters or more of induration is classified as positive in persons who do not meet the above criteria but who have other risk factors for tuberculosis. This would include: 1) foreign born persons from high prevalence countries in Asia, Africa and Latin America; 2) intravenous drug users; 3) homeless individuals; 4) residents of nursing homes; 5) residents of correctional institutions; and 6) persons with the following factors which increase the risk of tuberculosis-silicosis; diabetes mellitus; immunosuppressive therapy; some hematologic and reticuloendothelial diseases, such as leukemia or Hodgkin's Disease, end stage renal disease and clinical situations associated with substantial rapid weight loss or under nutrition. A reaction of fifteen millimeters or more of induration is classified as positive in all other persons. Negative reaction--For each of the above categories, reactions below the cutting point are considered negative.

JG/vdt-7xt

*MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 09/5/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	22 (46)	13 (59)
Other Disease w/o PCP	23 (48)	14 (64)
KS Alone	3 (6)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	48 (100)	27 (56)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	14 (29)
30-39	23 (48)
40-49	7 (15)
Over 49	4 (8)
Unknown	0 (0)
Total	48 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	44 (92)
Black, Not Hispanic	1 (2)
Hispanic	2 (4)
Other	1 (2)
Unknown	0 (0)
Total	48 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	28 (62)	0 (0)	28 (58)
Intravenous (IV) Drug User	6 (13)	0 (0)	6 (13)
Homo/Bi IV Drug User	5 (11)	0 (0)	5 (10)
Hemophiliac	3 (7)	0 (0)	3 (6)
Heterosexual Contact	0 (0)	3 (100)	3 (6)
Transfusion With Blood/ Products	0 (.0)	0 (0)	0 (0)
None of the Above/Other	3 (7)	0 (0)	3 (6)
Total	45 (100)	3 (100)	48 (100)

Source: Montana AIDS Program, MOHES, September 5, 1989

*Includes 34 Montana AIDS cases and 14 cases reported to Centers for Disease Control from other states who are living in Montana.

As of August 31, 1989 there have been 216 positive HIV tests from 16,534 tests conducted through the MOHES Public Health Laboratory.

Nationally, as of July 31, 1989, 102,621 cases of AIDS and 59,391 deaths have been reported to the Centers for Disease Control.

Volume: 13:9 **Month of:** August, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

Distributed without charge to health care providers at a cost of 6¢ per copy for printing and 7¢ per copy mailing.

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State Library (20)

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HELENA, MONTANA 59620

Montana Morbidity Report

Montana State Library
3 0864 1004 3486 2

PLEASE RETURN

VOLUME: 13:10

MONTH OF: Sept. 1989

Montana State Department of Health and Environmental Sciences

Montana Immunization Clinic Manual Now Distributed to Public Clinics

The first edition of the Montana Immunization Clinic Manual has been distributed to public immunization clinics by the Montana Immunization Program. The manual includes the following:

1. It cross references immunization recommendations and resources (and how to obtain them);
2. The recommendations of the Immunization Practices Advisory Committee (ACIP) is included in its entirety;
3. Discusses vaccine availability including vaccines provided through the Montana Immunization Program and those that are available through other sources;
4. Includes instructional for dose recovery of DPT vaccine and optimum needle length for inoculation of infants;
5. Has a section on adult immunization recommendations by age group, occupation, lifestyle, environmental situations, special health status, etc.;
6. Describes reporting of adverse event following immunizations by the public sector;
7. Includes the National Childhood Vaccine Injury Act;
8. Describes vaccine handling, ordering, shipping procedures and related forms;
9. Lists drug manufacturers with address and phone number;
10. Discusses things to be considered when having an immunization clinic away from the normal setting;
11. Discusses record retention and management;
12. Discusses international travel recommendations and where vaccines can be obtained, and;
13. Includes the Uniform Health Care and information Act.

Due to program funding and staff limitations, a single copy of the manual is being provided to each public clinic. Updates of the manual and ACIP will be provided only to public clinics. Those who wish access to the manual and/or copies should contact their local health department or other public clinic in their area to determine availability. The manual is also available through the Montana State Library. To borrow a copy from the Montana State Library: in Helena, contact the State Library directly; outside of the Helena area, either contact your local library which will obtain a copy for you or call the Montana State Library at 444-3004. (NOTE: The cost for the Montana Immunization Program to develop and distribute the manual was $64.00 per copy.)

ISG For Sale

Missoula City-County Health Department has 250 10cc vials of Immune Serum Globulin (ISG) available. Purchase cost for the ISG was $7.50 per vial. They will sacrifice for $5.00 per vial. The expiration date is April of 1992. If you are interested in purchasing some or all of the ISG, please contact Roxy Anderson, Nursing Supervisor for Missoula City-County Health Department at 523-4750, extension 3388.

SEPTEMBER 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		3													
Big Horn		2		2		2									
Blaine		2													
Broadwater															
Carbon															
Carter															
Cascade	2	26		4							1		1		
Chouteau															
Custer		2													
Daniels															
Dawson		1											1		
Deer Lodge															
Fallon															
Fergus															
Flathead	1	4	9	2		3			1			1			
Gallatin	1	11	2	1		1									
Garfield															
Glacier		5		4							1		1	1	
Golden Valley															
Granite															
Hill		5	1			6									
Jefferson															
Judith Basin															
Lake		3	1	1		3									
Lewis & Clark		9	1								1		1	1	
Liberty															
Lincoln		1		1								1			
McCone		1												1	
Madison															
Meagher															
Mineral															
Missoula	8	10	6			8	2							3	
Musselshell															
Park		2									1			1	
Petroleum															
Phillips		2										1			
Pondera															
Powder River															
Powell															
Prairie															
Ravalli		1	1												
Richland		1													
Roosevelt		4	2								1			3	
Rosebud		2	1	1		1								8	
Sanders															
Sheridan															
Silver Bow		4		1									1		
Stillwater		1										1			
Sweet Grass		1													
Teton			1												
Toole															
Treasure															
Valley															
Wheatland		1													
Wibaux															
Yellowstone	5	18	3	3							2	2		2	
MONTHLY TOTAL 19 89	17	122	28	20	0	24	2	0	1	0	7	6	5	20	0
MONTHLY TOTAL 19 88	12	140	47	27	1	4	6	1	1	0	15	12	14	34	3
MONTHLY TOTAL 19 87	2	142	21	56	1	7	4	0	1	1	5	13	10	3	1
TOTAL TO DATE 19 89	84	1029	123	159	7	68	39	5	3	1	74	68	52	93	12
TOTAL TO DATE 19 88	62	1501	167	316	8	30	43	10	4	1	71	172	75	161	15
TOTAL TO DATE 19 87	29	1256	111	460	12	70	41	9	4	4	84	95	59	23	10

OTHER DISEASES: Chickenpox: Gallatin, 1; Cytomegalo Viral Illness: Cascade, 1; Mumps: Gallatin, 2; Pertussis: Hill, 1; Silver Bow, 2; Yellowstone, 1

DELETION: Hepatitis A: Rosebud, 1

Measles Reported in Idaho

Measles has been recently reported in Idaho. Seven (7) cases of measles have been serologically confirmed and eleven (11) other cases are under investigation in Canyon County, Idaho. In addition, two (2) cases are under investigation in Gem County and one (1) case is being investigated in Payette County. The onset of rash illness for the first confirmed case was August 24, 1989. The latest suspected case of measles had an onset date of October 5, 1989. The range of all cases is from six (6) months to nineteen (19) years of age.

All suspected measles cases in Montana are required to be reported immediately to the local health department or the Montana Department of Health and Environmental Sciences. Immediate telephone reporting of measles cases is required by the Administrative Rules of Montana (ARM). To report cases to the department, contact the Montana Immunization Program at (406) 444-4740.

Keep Measles A Memory - Immunize!

***MONTANA**
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 10/2/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	23 (45)	13 (57)
Other Disease w/o PCP	25 (49)	15 (60)
KS Alone	3 (6)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	51 (100)	27 (55)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	15 (29)
30-39	23 (45)
40-49	8 (16)
Over 49	5 (10)
Unknown	0 (0)
Total	51 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	46 (90)
Black, Not Hispanic	1 (2)
Hispanic	2 (4)
Other	2 (4)
Unknown	0 (0)
Total	51 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	30 (64)	0 (0)	30 (59)
Intravenous (IV) Drug User	6 (13)	0 (0)	6 (12)
Homo/Bi IV Drug User	5 (11)	0 (0)	5 (10)
Hemophiliac	3 (6)	0 (0)	3 (6)
Heterosexual Contact	0 (0)	3 (75)	3 (6)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (6)	1 (25)	4 (8)
Total	47 (100)	4 (100)	51 (100)

Source: Montana AIDS Program, MDHES, October 2, 1989

*Includes 37 Montana AIDS cases and 14 cases reported to Centers for Disease Control from other states who are living in Montana.

As of September 30, 1989 there have been 220 positive HIV tests from 16,994 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of August 31, 1989, 105,991 cases of AIDS and 61,655 deaths have been reported to the Centers for Disease Control.

* *
* HIV/AIDS INFORMATION *
* *

TREATMENT AND RESEARCH

Import Alert on Unapproved New Drugs and Ozone Generators

The Import Operations Branch of the Food and Drug Administration has released the following alert.

Equipment intended to generate ozone for a medical purpose is considered a device as that term is defined in section 201(h). The ozone itself, however, when intended for use in or on the body is considered a "drug" as defined in section 201(p). Ozone generators and the use of ozone gas for the treatment of AIDS may present a potentially serious health hazard. Ozone has a known pulmonary toxicity, and ozone gas and ozone solution can explode which could endanger individuals in its vicinity.

Director, Division of Federal-State Relations, Food and Drug Administration, August 31, 1989.

State of Residence for AIDS Cases

"State of residence" is collected on each AIDS patient reported to CDC. This has been defined as "the patient's city and state of residence at the time of the onset of AIDS-related symptoms, not necessarily the residence at the time or diagnosis, hospitalization, or report." AS OF JULY 1, 1989, "STATE OF RESIDENCE AT THE INITIAL DIAGNOSIS OF AIDS" SHOULD BE SUBSTITUTED FOR "state of residence at onset of illness suggestive of AIDS" which appears on the AIDS case report form.

If there are any questions regarding this change of policy, please contact MDHES at 444-4740.

HIV Infection Reporting-- United States

State reporting systems vary widely in methodology and type of information collected. All 50 states and the District of Columbia require reporting of AIDS cases to state health departments by health-care providers. As of July, 1989, 28 states, including Montana, require reporting of HIV infections, and these states report lower cumulative incidence of AIDS. HIV infection reports may enable earlier recognition of at-risk individuals and earlier intervention for treatment and transmission prevention.

Centers for Disease Control Morbidity and Mortality Weekly Report (07/20/89)

HIV Infection in Emergency Department Patients

In a study to assess the impact of the human immunodeficiency virus epidemic on The Johns Hopkins Hospital Emergency Department, it was found that 152 (6.0%) of 2544 consecutive patients were found to have human immunodeficiency virus infection, an absolute increase of 0.8% from the previous year. Of the 57 patients with a known history of infection, 49.1% had no insurance vs 36.0% of seronegative patients. Overall, health providers followed universal precautions during 44.0% of interventions. In patients with profuse bleeding, adherence fell to 19.5% The most common reasons given by providers for not following precautions were insufficient time to put on protective attire and interference with procedural skills. It was concluded that the human immunodeficiency virus epidemic has a major impact on emergency services and that strategies need to be developed for appropriate use of emergency resources and also for maximizing provider protection.

Journal of American Medical Association (07/28/89) Vol. 262, No. 4

AIDS Treatment Drug Delays Progression of Disease

A multicenter AIDS drug trial with more than 3,200 volunteers has shown that zidovudine (AZT) delays progression of disease in certain HIV-infected persons who have not yet developed symptoms. About 1,300 of the 3,200 participants had fewer than 500 T4 cells upon entry. The study will continue for persons whose T4 counts are above 500, since the study has shown that short-term risk of developing

AIDS is negligible in persons with higher T4 counts.

The study showed the symptoms were about the same in patients receiving 500 mg per day or 1,500 mg per day of the drug. Toxicities were minimal in both treatment groups. More importantly, with the exception of nausea that occurred in about 3 percent of the volunteers, virtually no differences in side effects were observed in persons receiving the lower dose and persons receiving placebo.

The results of this study will have a fundamental impact on services and education from the standpoint of testing and counseling, case management, and hot lines. With the use of AZT and other therapies, HIV disease is on its way to becoming a chronic, manageable disease.

Zidovudine is manufactured by Burroughs Wellcome Co. and is available under the trademark Retrovir. Its effectiveness in extending the lives of persons with AIDS was first announced in September, 1986. It was approved in March, 1987 for treatment of AIDS patients who had recovered from Pneumocystis carinii pneumonia and patients with advanced ARC.

HHS News, U.S. Department of Health and Human Services

TRENDS

Morbidity and Mortality Weekly Report: Current Trends--First 100,000 Cases of AIDS--United States

The first five AIDS cases were reported in Los Angeles in June, 1981. Since then more than 100,000 cases of AIDS have been reported by state and territorial health departments. The first 50,000 cases were reported between 1981 and 1987. However, the second 50,000 cases were reported between December, 1987 and July, 1989. AIDS ranked 15th among leading causes of death in 1988 and seventh among estimated years of potential life lost before age 65 in 1987. IV drug users, their sexual partners, and their children represent a rapidly increasing proportion of AIDS cases, although homosexual and bisexual men still account for most of the reported cases. Blacks and Hispanics still represent a disproportionate number of AIDS cases, particularly among IV drug users. An increasing proportion of AIDS cases is being reported among women, and also from smaller cities and rural areas as opposed to large metropolitan areas. The 100,000 AIDS cases reported to the CDC grossly underestimate the number of people severely infected by HIV since 1981, however, because of a combination of underdiagnosis, underreporting of cases, and several manifestations of HIV infections that do not meet CDC AIDS case definitions.

Centers for Disease Control (08/17/89)

Insurance Company to Pay for AZT Based on NIAID Guidelines

John Alden's Life is the first insurance company to announce that it will follow the National Institute of Allergy and Infectious Disease's (NIAID) recommendations for zidovudine (AZT) intervention in early symptomatic HIV infection in Alden's Patient Advocacy Program. All of the company's insureds who have symptomatic HIV infection with a T4 cell count less than 500 can have their AZT prescriptions reimbursed. Insureds will have to enroll in the Patient Advocacy Program and order their AZT through Family Pharmaceuticals of Mt. Pleasant, South Carolina.

John Alden Life's decision to base its reimbursement policy on NIAID's clinic trial data reinforces FDA Commissioner Frank Young's position that third-part payors should not base reimbursement policies on FDA labeling which is designed for the marketing of the drug and not intended to be the standard of whether a drug was or was not investigational or appropriate treatment. John Alden Life has based its reimbursement guidelines on independent evaluations of clinical data provided through the Physicians Association for AIDS Care (PAAC) and other scientific groups. John Alden Life previously reimbursed for AZT for insureds with T4 cell count under 400 which was considered one of the more liberal guidelines in the insurance industry.

News Release. AIDS Medical Resource Center

Gay Men's Health Crisis Announces Campaign to Encourage HIV Testing

Richard Dunne, the Executive Director of Gay Men's Health Crisis, announced an expanded campaign to encourage more volun-

tary HIV-testing. This reversal in attitude came about because recent studies of the drug AZT have indicated that it works not only for people with AIDS but also for those who have symptomatic HIV infections but not AIDS. Other drugs such as aerosol pentamidine prevent the pneumonia which is the number one killer of people with AIDS.

Press release. GMHC

RESOURCES

Business and Labor Speak Out, published by the National Leadership Coalition on AIDS (NLCOA). Topics: The challenge to business, a need for civic responsibility, and a call for leadership. Bulk copies free from NLCOA, 1150 17th Street NW, Suite 202, Washington, DC. 20036, 202/429-0930.

AIDS Clinical Care, a new monthly periodical focusing on the diagnosis and treatment of HIV-related diseases and dealing with the clinical aspects of AIDs patient care. Content: feature articles by leading AIDS clinicians, articles written by people with AIDS, concise summaries of key AIDS-related clinical articles from medical literature, and extensive quick-reference charts and tables of treatment regimes, statistics, and diagnostic methods. Subscriptions are $68.00/year. Call 1-800/843-6356

The American Association for Counseling and Development (AACD) has released No Longer Immune: A Counselor's Guide to AIDS. Chapters include culturally sensitive AIDS counseling, special needs of adolescents, and modern hospice care. Cost $24.95 Contact AACD, 5999 Stevenson Avenue, Alexandria, VA 22304. 1-800/545-AACD.

Foundation Fundamentals for Nonprofit Organizations: Guides grantseekers through the process of researching appropriate funders and covers matching foundation interests, the prospect research process, and using Foundation Center publications and library resources. Sources of funding and basic proposal-writing guidelines are included. The videotape is $19.95, plus $2.00 shipping and handling, from the Foundation Center, 79 Fifth Avenue, New York, NY 10003. 1-800/424-9836.

Gonorrhea Screening Trends

Figure 1 below illustrates the stable amount of screening that has occurred in Montana in recent years in females and the projected decline in 1989, based on the first 9 months experience. Figure 2 demonstrates the declining positivity rates for all providers in recent years. (The other category includes military, state institutions, job corps and others.) The declining positivity rates support the real decline in gonorrhea in the state, assuming we are still screening those at risk of disease.

Another way of approaching it is reviewing gonorrhea morbidity trends in surrounding states, which show that for the first nine months of 1989 gonorrhea morbidity has declined 58% in Montana, 53% in Wyoming, 50% in Idaho, 51% in South Dakota, 27% in North Dakota, 18% in Utah and a national decline of 4.5%, compared to the corresponding period in 1988.

Next month we will look at the state public health laboratory's experience in chlamydia screening by type of provider, age, sex and geographical areas for 1989.

1989 STD Treatment Guidelines

The 1989 sexually transmitted disease treatment guidelines were issued by the Centers for Disease Control as a supplement in a Morbidity and Mortality Weekly Report on September 1, 1989. Plans are to reprint the guidelines in an 8 1/2 by 11 format for the STD Program Manual to be distributed to local public health agencies by the end of the year. Others may request a copy of the treatment guidelines by writing to Bruce Desonia, STD Program, Cogswell Building, Helena, Montana 59620.

Dual Therapy Utilized

During the first nine months of 1989, 116 of the 159 reported gonorrhea patients treated received dual therapy, which was adequate for a potentially coexisting chlamydia infection. Dual therapy is recommended since many gonorrhea patients are found to be also infected with chlamydia infection.

Fig.1. Gonorrhea Screening in Females

by Provider, Montana, 1984–1989

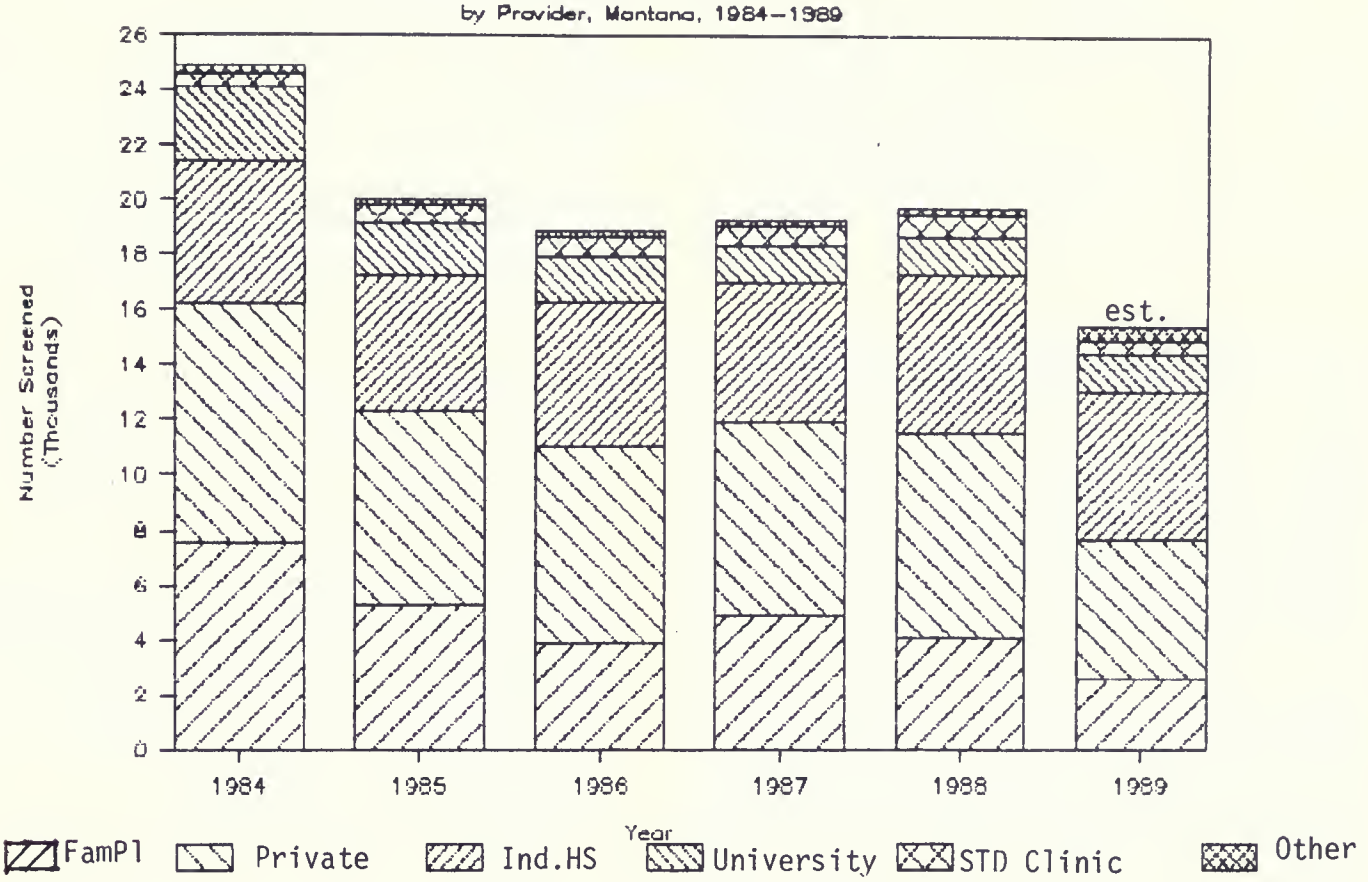
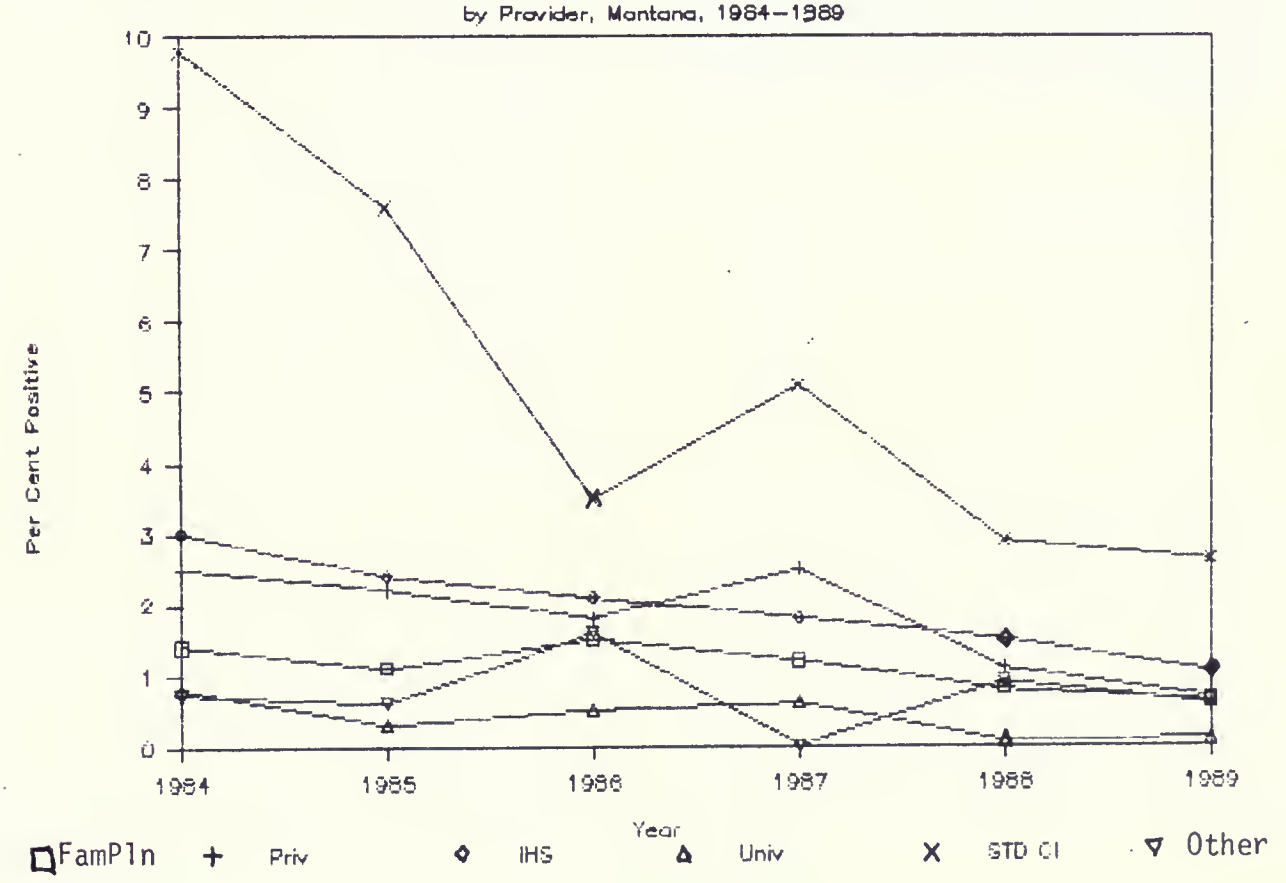


Fig.2. Gonorrhea Positivity Rates in Females

by Provider, Montana, 1984–1989



No Endemic Lyme Disease in Montana at this Time

Tick borne diseases, especially Lyme Disease have received much attention in the popular press during the past six months. There is no evidence the Borreliosis caused by Borrelia burgdorferi spirochetes exists in Montana at this time. This conclusion has been reached after a MDHES team has spent over one year aggressively searching for cases of Lyme disease in the state.

MDHES Public Health Laboratory has received nearly 1000 specimens with requests for them to be analyzed to detect evidence of Borrelia burgdorferi infection. The results for specimens which indicated a possibility of B. burgdorferi infection at anytime in the past were forwarded to the Preventive Health Services Bureau for further investigation. Using the case definition developed by the Centers for Disease Control in collaboration with the Council of State and Territorial Epidemiologists each case was further scrutinized. None of the approximately 3 dozen reports for which further information could be obtained was consistent with the case definition.

To further delve into whether or not endemic Lyme disease is occurring in Montana, the Department entomologist has been consulted regarding the tick vectors known to be responsible for transmitting B. burgdorferi to man. There is no evidence proven vectors occur in Montana. One must remember only 4 species of Ixodes ticks are known to transmit Lyme disease . . . and even in areas where Lyme disease is endemic only 2-40% of ticks will be found to harbor B. burgdorferi.

Since there is no evidence of endemic Lyme disease in Montana, MDHES Public Health Laboratory and the Preventive Health Services Bureau will not continue the investigations done during the past year. Laboratory specimens for analysis to determine infection with B. burgdoferi will be processed only if there is supporting clinical evidence of the disease. Tick surveillance will be maintained to determine whether or not the proven vector has arrived or whether or not potential vectors occur in the state.

Volume: 13:10 **Month of:** September, 1989

MONTANA MORBIDITY REPORT. ISSN # 0745-5129Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

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Volume: 13:11

Month of: Oct., 1989

Montana State Department of Health and Environmental Sciences

Billings Salmonella Outbreak 1989

Based on the information Montana Department of Health and Environmental Sciences has as of November 3, 1989 there have been at least 53 cases of Salmonellosis associated with unsatisfactory food handling procedures employed by a restaurant in Billings. A funeral luncheon catered by the restaurant on September 30, 1989 was the sentinal event in alerting Yellowstone City-County Health Department to problems at the restaurant. There are patrons other than those who had food catered from the restaurant and contacts to primary cases who became ill with the last known onset being during the last week of October.

The chicken specialty restaurant has a sit-down operation as well as providing carry-out and catering. From September 28,1989 to October 15,1989 at least 17 events were catered by this food service establishment. Groups of persons eating at two of these catered events, the other 15 groups were not contacted, became ill with symptoms including nausea, vomiting, diarrhea, malaise, abdominal cramps and headache. Of the cases interviewed and symptom profile recorded the most prominent symptom was diahrrea. Twenty-five of the cases were confirmed by stool specimen and the common sero-group of the Salmonella is D1.

Restaurant inspection done on October 12, 1989 noted several practices which could allow for raw uncooked foods to be contaminated by fresh uncooked chicken. One worker was shifting back and forth between chicken cutting and lettuce salad preparation. There was potential for cross contamination in the cooking area between food contact and non-food contact surfaces. Three employees in the restaurant were stool positive for Salmonella when tested during a screening of all employees. A food service worker in another restaurant was stool positive after being infected at one of the functions catered by the implicated restaurant.

Over the past few years, an increase in Salmonella infection of poultry and poultry products entering the food chain has been noted in the United States with the Northeastern states being documented as hardest hit by this. In the absence of information about routine poultry testing being done in Montana, one can turn to Salmonellosis cases reported to MDHES as an indication of whether or not a trend towards increased Salmonella exposure is occurring. Cases of Salmonellosis reported to MDHES in the respective yearsare recorded as illustrated below:

Year	Salmonellosis Cases Reported
1988	96
1987	74
1986	65
1985	89
1984	61

Prevention of food-borne outbreaks is cost effective. At least 6 persons involved in this outbreak were hospitlized as in-patients. Centers for Disease Control has determined each day of hospitalization for those with Salmonellosis in another outbreak cost $1200. Average cost of diagnosis and treatment of a non-hospitalized case is about $150. One also has to consider the cost of missed work by cases and the food-handlers some of which were not back to work by the last week of October.

OCTOBER 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1													
Big Horn		1													
Blaine		5													1
Broadwater															
Carbon													1		
Carter															
Cascade		13	14	4							1				
Chouteau		2													
Custer		2		1											
Daniels															
Dawson		1											1		
Deer Lodge		2									1		1		
Fallon															
Fergus		2		1											
Flathead	1	4	2			1									1
Gallatin		26	3			1					1				
Garfield															
Glacier		6	1	1											1
Golden Valley															
Granite															
Hill		5				3									
Jefferson	1														
Judith Basin															
Lake		1			1	9									
Lewis & Clark		16													
Liberty															
Lincoln		4													
McCone															
Madison															
Meagher															
Mineral															
Missoula	2	11	1	1	1		1								
Musselshell											2				
Park															
Petroleum															
Phillips		1													
Pondera											1				
Powder River		1													
Powell															
Prairie															
Ravalli		3													
Richland		1													
Roosevelt	1	3		4										1	1
Rosebud		1													
Sanders		1													
Sheridan				2							1				
Silver Bow		4	1							1					
Stillwater															
Sweet Grass		1	2												
Teton															
Toole															
Treasure															
Valley											1	1			
Wheatland															
Wibaux															
Yellowstone	1	26	5	4			1				1		21	1	1
MONTHLY TOTAL 19 89	6	144	29	18	2	14	2	0	0	1	9	1	24	2	5
MONTHLY TOTAL 19 88	9	133	17	26	1	6	3	0	0	0	11	18	10	27	4
MONTHLY TOTAL 19 87	4	190	24	54	5	9	5	0	0	0	24	10	9	4	2
TOTAL TO DATE 19 89	90	1173	152	177	9	82	41	5	3	4	83	69	76	95	17
TOTAL TO DATE 19 88	71	1634	184	342	9	36	46	10	4	1	82	190	85	188	19
TOTAL TO DATE 19 87	33	1146	135	514	17	80	46	9	3	4	102	105	68	27	12

OTHER DISEASES: Aseptic Meningitis: Jefferson, 1; Chickenpox: Cascade, 1; Yellowstone, 3; Cytomegalo Viral Illness: Missoula, 1; Legionellosis: Cascade, 1; Pertussis: Cascade, 1; Gallatin, 1; Park, 1; Yellowstone, 1

* *
* HIV/AIDS INFORMATION *
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TREATMENT AND RESEARCH

Clinical Trials for DDI

The Food and Drug Administration (FDA) and the National Institutes of Health (NIH) have developed a comprehensive plan for clinical evaluation and expanded availability of DDI (Dideoxyinosine). The clinical trials will enroll 2600 persons with AIDS or AIDS related complex (ARC). The FDA has also granted the drug manufacturer permission to distribute DDI through a treatment IND (investigational new drug) for patients with AIDS or advanced ARC who cannot take zidovudine (commonly called AZT) because of serious drug toxicity. The FDA granted the company permission to distribute DDI under an open safety protocol for AIDS patients whose disease has substantially progressed despite zidovudine therapy and who have no other treatment options.

Dideoxyinosine is one of a group of drugs, ncluding zidovudine, that inhibit replication of the AIDS virus. While DDI appears promising, it has toxicities related to the dose taken; thus, its use requires careful monitoring. Although studies reported earlier this year indicated that DDI could be tolerated by most AIDS patients, more recent data indicate that some patients taking DDI, particularly at higher doses, have experienced painful nerve damage to the feet and, less commonly, damage to the pancreas. These toxicities appear to be reversible if detected early and if the drug is discontinued.

Despite the promising early results with DDI, it is important to emphasize that zidovudine is the only drug with proven efficacy for the treatment of patients with AIDS and advanced ARC.

Director, Division of Federal-State Relations, Food and Drug Administration.

Hotline for Pentamidine Clinical Information

Lyphomed, the pharmaceutical company that manufactures aerosolized pentamidine under the brand name of Nebupent, has a Hotline set up to answer questions from providers who want to use the drug in their practices. Aerosolized pentamidine is used prophylactically in the treatment of pneumocystis carinii pneumonia. The 24-hour number is 312-345-9746. This is not a toll free call. A ten minute video about the use of the product clinically is also available. Lyphomed's address is 10401 West Touhy Avenue, Lynnwood, Washington, 98037.

Montana AIDS Prevention Act

The AIDS Prevention Act (SB 437) became effective October 1, 1989. In the absence of a vaccine or cure, control of this epidemic is dependent on education aimed at those people infected or at risk for infection. AIDS is caused by Human Immunodeficiency Virus. The virus is spread predominately through sexual and intravenous drug use behavior. The intent of this law is to control the epidemic through education.

This law also requires written informed consent be obtained from the person being tested before an HIV Antibody Test can be done.

The Montana Department of Health and Environmental Sciences in accordance with the AIDS Prevention Act (SB 437), has developed written materials that must be given to a person before an HIV Antibody blood test is done and materials that must be given to a person at the same time he or she receives the results of the test. A written informed consent must also be obtained before an HIV Antibody Test is done. MDHES has developed a written informed consent form that may be used.

MDHES has mailed information and materials to all physicians, hospitals, nursing homes, counseling and testing sites, family planning clinics and state institutions. If you would like to receive the information and materials, or have any

questions, please contact the Montana Department of Health and Environmental Sciences, AIDS/STD Program at 444-4740.

Food and Drug Administration Grants Permission for Zidovudine (AZT)

HHS Secretary, Louis W. Sullivan, M.D., recently announced that the Food and Drug Administration has granted permission for distribution of zidovudine, commonly called AZT, for use in treating children under the age of 13 who have AIDS or who are suffering from symptoms of advanced infections with the AIDS virus.

Zidovudine will be distributed free of charge to children with AIDS or at advanced stages of AIDS virus infection under a Treatment IND (investigational new drug) program sponsored by the Burroughs Wellcome Company of Research Triangle Park, N.C., with medical and technical assistance by the National Institute of Allergy and Infectious Diseases (NIAID), a component of the National Institutes of Health (NIH).

Physicians interested in enrolling patients in the Treatment IND protocol can call the Burroughs Wellcome toll-free number at 1-800-829-PEDS from 8 a.m. to 7 p.m., Eastern Time.

From a press release from William Heinz, Director, Division of Federal-State Relations, FDA.

RESOURCES

New Aids Medical Journal for Physicians

PAACNOTES is the name of a new medical journal being published for physicians. The journal covers a wide variety of topics including clinical management, ethical concerns, legal and political issues, drug updates and research updates. It is published every two months by the Physicians Association for AIDS Care (PAAC). A subscription to PAACNOTES is included in PAAC membership dues. Subscription rates to non-members is $60.00 per year. If interested, please write to PAACNOTES, 101 West Grand Avenue, Suite 200, Chicago, Illinois, 60610.

University of Washington AIDS Education and Training Center Program announced a schedule for their courses designed for health care providers interested in developing or improving their knowledge and skills in providing AIDS education to other health care providers. The range of course topics include information on etiology, epidemiology, transmission and infection control, testing and counseling, legal and ethical issues, medical and case management, psycho-social aspects, minority and cultural issues, drugs and HIV, sexuality and instruction on how to teach about AIDS and design an AIDS education program.

Schedule for 1989-1990

November 13-17	Seattle, WA
January 23-26	Bozeman, MT
February 27-March 2	Spokane, WA
March 13-16	Fairbanks, AK
April 17-20	Boise, ID
May 14-18	Seattle, WA

For an application call (406) 994-3532.

"AIDS Prevention Guide" for Adults Concerned About Youth

Phase three of the PHS/CDC "AMERICA RESPONDS TO AIDS" campaign started in late May, a new public information campaign targeting parents and youth. The new campaign includes new AIDS public service announcements (PSAs) directed at parents about their children and an AIDS Prevention Guide for parents and other adults concerned about young people and AIDS. The Guide is designed to motivate parents to talk with their children about AIDS and about how to prevent HIV infection. In developing the Guide, CDC's National AIDS Information and Education Program (NAIEP) conferred with specialists in the fields of education, child development, health care, biological science and communication. Leading national health and educational associations were also consulted.

Copies of the AIDS Prevention Guide (in English and Spanish) can be obtained by contacting the AIDS Clearinghouse. Their address and phone number is:

The National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850
1-800-458-5231

HIV and HBV Guidelines for Health Care Workers

On June 23, 1989 CDC printed "Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers" in the Morbidity and Mortality Weekly Report (MMWR 1989;38(S-6):1-37). These guidelines were published in response to the Health Omnibus Programs Extension Act of 1988 ("AIDS Amendments of 1988"). Information about the hepatitis B virus (HBV) is included with the HIV recommendations because transmission routes are similar, potential for HBV transmission in an occupational setting is greater than for HIV and precautions against transmission of HBV will also minimize the risk of transmission of HIV. This MMWR supplement includes sections on infection control practices for emergency and public-safety workers, employer responsibilities, specific information for fire and emergency medical services personnel and specific recommendations for law enforcement and correctional-facility officers.

A single copy of these guidelines is available by writing to Technical Information Services (E-06), Center for Prevention Services, Centers for Disease Control, Atlanta, Georgia 30333. Additional copies can be obtained by contacting:

The National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850
1-800-458-5231

Montana Chlamydia Trends

The morbidity reports for chlamydia have increased from 150 in 1985, to 666 in 1986, 1,775 in 1987, 1,957 in 1988 and 1,160 for the first ten months of 1989. 968/1,160, or 83% of the 1989 cases were tested through the State Public Health Laboratory (PHL).

The cases reported from the State PHL were analyzed by geographic area, sex, age and type of health care provider, for the first 9 months of 1989. There were no significant differences when viewed by nine geographical areas of the state.

The positivity rate for tests done at the State PHL has declined in recent years, as the number of tests performed has increased, as shown in Table 1.

Table 1.
Chlamydia Tests
Montana Public Health Laboratory

Year	Number of Tests	Number Positive	Percent Positive
1986	4,982	480	9.6%
1987	14,569	1,571	10.8%
1988	26,802	1,736	6.5%
1989*	19,232	968	5.0%

*January-October 1989

The number of positive female reports, by age group and number tested, is listed in Table 2 below. The overall positivity rate was 5.4% for the women screened. The 11,520 tests performed represent only about 8.3% of the 138,600 females in the age group 15-34, potentially at risk. Of the women tested, 7,776/11,520, or 67% were in women under age 26. The higher positivity rate for those under age 21 is consistent with trends for chlamydia elsewhere in the region.

Table 2.
Female Chlamydia Reports
By Age Group
Montana Public Health Laboratory
January - September 1989

Age Group	Number of Tests	Number Positive	Percent Positive
11-15	485	39	8.0%
16-20	4,304	355	8.2%
21-25	2,978	155	5.2%
26-30	1,875	47	2.5%
31+	1,878	23	1.2%

Next month we will look at the number of tests and positivity rates by type of provider.

*MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 10/2/89

1. Disease Category

Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	23 (45)	13 (57)
Other Disease w/o PCP	25 (49)	15 (60)
KS Alone	3 (6)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	51 (100)	27 (55)

2. Age

Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	15 (29)
30-39	23 (45)
40-49	8 (16)
Over 49	5 (10)
Unknown	0 (0)
Total	51 (100)

3. Race/Ethnicity

Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	46 (90)
Black, Not Hispanic	1 (2)
Hispanic	2 (4)
Native American	2 (4)
Unknown	0 (0)
Total	51 (100)

4. Patient Groups

Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	30 (64)	0 (0)	30 (59)
Intravenous (IV) Drug User	6 (13)	0 (0)	6 (12)
Homo/Bi IV Drug User	5 (11)	0 (0)	5 (10)
Hemophiliac	3 (6)	0 (0)	3 (6)
Heterosexual Contact	0 (0)	3 (75)	3 (6)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (6)	1 (25)	4 (8)
Total	47 (100)	4 (100)	51 (100)

Source: Montana AIDS Program, MDHES, October 2, 1989

*Includes 37 Montana AIDS cases and 14 cases reported to Centers for Disease Control from other states who are living in Montana.

As of September 30, 1989 there have been 220 positive HIV tests from 16,994 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of August 31, 1989, 105,991 cases of AIDS and 61,655 deaths have been reported to the Centers for Disease Control.

DK/war-xt

Require Hib Vaccination in Child Care Settings

Hib vaccination should occur in all children 18 months to 5 years of age. The Department recommends that local health departments and child care operators require Hib immunization for entry into child care settings. Although the Administrative Rules of Montana relating to licensed day care centers need to be amended to include Hib immunization, it should not delay implementing a requirement in all child care settings.

Apparently some head start health coordinators in the federal Region VIII have expressed concern regarding the availability of Hib vaccine since "community health nurses have not made the vaccine available for three and four year old children." This should not be the case in Montana. Hib vaccine is available from the Montana Immunization Program to all public providers and should be used in all children age 18 months to five years of age. For further information on the recommendations for use of Hib vaccine, refer to the Montana Immunization Manual or contact your local health department or the Montana Immunization Program at 444-4740.

Reminder to Public Vaccination Clinics

The Montana Immunization Program will be moving to a once per quarter vaccine shipping schedule by April 1990. At that time, public vaccine providers will need to order a 5 to 6 month supply of vaccine and should not expect additional vaccine between the 3 month shipping interval, except in outbreaks. Additional information on this will follow the receipt of the 1990 vaccine grant award in January.

Appropriate Tetanus Product

Studies have shown, as many as 60 percent of treatments with tetanus immunizing materials involve the use of an inappropriate product. Overuse of tetanus toxoid should be discontinued because many adults have uncomfortable reactions if immunized with toxoids more than every ten years as recommended. Below you will find reproduced, a table from the document entitled "Adult Immunizations" produced by the Centers for Disease Control. This table is a handy reference for determining whether tetanus toxoid with a small amount of diphtheria antigen for adults or tetanus immune globulin should be used.

Summary guide to tetanus prophylaxis in routine wound management

History of tetanus immunization (doses)	Clean, minor wounds		All other wounds	
	Td*	TIG†	Td*	TIG†
Uncertain	Yes	No	Yes	Yes
0-1	Yes	No	Yes	Yes
2	Yes	No	Yes	No§
3 or more	No¶	No	No**	No

NOTE: Refer to text on specific vaccines or toxoids for contraindications, precautions, dosages, side effects and adverse reactions, and special considerations. Important details are in the text and ACIP recommendation (MMWR 1981; 30:392-407).

*The combined preparations Td, containing both tetanus and diphtheria toxoids, is preferred to tetanus toxoid alone.

†Tetanus immune globulin.

§Yes, if wound more than 24 hours old.

¶Yes, if more than 10 years since last dose.

**Yes, if more than 5 years since last dose (more frequent boosters are not needed and can accentuate side effects.)

Mefloquine Approved for Malaria

Mefloquine (Lariam) has been approved for the treatment and prevention of infection with two malaria parasites. Plasmodium falciparum and Plasmodium vivax including those strains of P. falciparum resistant to other anti-malarial drugs.

In many areas of the world, including Southeast Asia, Africa, and South and Central America, many strains of P. falciparum parasites have become resistant to chloroquine, the main stay of treatment and prevention of malaria. Mefloquine has been shown to kill P. falciparum and P. vivax parasites in red blood cells. In clinical trials carried out in South America and Southeast Asia involving more than 1,000 patients, the drug was found to be highly effective in destroying the parasites in infected individuals with mild to moderate illness. In addition to treatment studies separate studies showed mefloquine to be effective in preventing malarial infections. It is recommended for travelers to areas where malaria is endemic, particularly where P. falciparum is resistant to other anti-malarial drugs. Oral prophylaxis should be started one week before visiting the area, continued while there and for four additional weeks after returning to this country. The recommended dosage regimen is one 250 mg. tablet once a week for four weeks, then one tablet every other week.

The drug must be used carefully in patients taking beta blockers, quinidine, and quinine because of the potential for arrhythmias when given in combination with these other drugs. In patients taking mefloquine in addition to anti-convulsant drugs, blood levels of the anti-convulsant drugs should be monitored because break through seizures and unexpectedly low anti-epileptic drug blood levels have been reported, the effects of mefloquine on the fetus are not known therefore, women of child bearing potential who are traveling to areas where malaria is endemic (and who plan to take mefloquine) should be warned against becoming pregnant.

Reference: 1) DHHS. FDA Drug Bulletin 1989; 19(2):17.

From: September 1989 Epidemiology Report, New Mexico Health and Environment Department.

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Montana State Department of Health and Environmental Sciences

* *
* HIV/AIDS INFORMATION *
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TREATMENT AND RESEARCH

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From a press release from William Heinz, Director, Division of Federal-State Relations, FDA.

World AIDS Day in Montana

The U.S. Department of Health and Human Services and the World Health Organization have proclaimed December 1, 1989 as World AIDS Day. With over 150,000 cases of AIDS reported from nearly 150 countries around the world, AIDS prevention and control activities need to be brought to more and more people.

The Montana Department of Health and Environmental Sciences joined in World AIDS Day activities by recognizing community volunteers for their efforts in AIDS related community service work. Ten persons from across Montana were presented with certificates from the MDHES acknowledging their local community work. Persons being given these certificates are: Vonda Brewster, David Herrera, Donna Davis, Mary Hernandez, F. Woodside Wright, Claudia Montagne, William Summers, Jewell Dalgarno, Mary Birch and Jane Korin.

From this group of local community volunteers, Mary Birch was chosen as the outstanding community volunteer. She received a special certificate from MDHES and Governor Stephens. A special ceremony took place in the Governor's Office on November 30, 1989.

PLEASE RETURN

Videotape to Alert People Infected With The AIDS Virus of the Special Dangers That Food-Borne Illnesses Pose to Them

The food and Drug Administration and the Centers for Disease Control began distributing the first videotape ever produced to alert people infected with the AIDS virus of the special dangers that food-borne illnesses pose to them. The 15-minute videotape warns that although the AIDS virus cannot be transmitted through foods, individuals with AIDS, because of their lowered immune systems, can develop serious or life-threatening illnesses through food such as raw or lightly cooked eggs, meats, and seafoods, as well as unwashed produce, or food prepared or handled in an unsanitary manner.

Peter Hawley, M.D., director of the Whitman-Walker Clinic of Washington, DC, and others affiliated with the clinic are also featured in the videotape. Dr. Hawley points out that AIDS patients and even those at earlier stages of AIDS virus infection can be much more susceptible to such food-borne infections as salmonellosis, listeriosis and campylobacterosis. Moreover, he notes that these people are far more likely to develop bloodstream infections, meningitis, and other serious, even potentially fatal, conditions from these food-borne infections.

The videotape instructs individuals with AIDS on how they can dramatically lower their risk of contracting harmful food-borne illnesses through carefully choosing the right foods, and following preparation and handling techniques in the kitchen. Special emphasis is placed on thoroughly cooking food to kill harmful organisms, and on thorough and repeated cleaning of any utensil, surface or other object (including hands) that come into contact with food during its preparation or handling.

Information and advice is also given on how to minimize the risk of contracting food-borne infections when dining away from home, including during travel abroad.

A copy of the video can be obtained through the CDC's National AIDS Information Clearinghouse at 1-800-458-5231 or by contacting the Montana Department of Health and Environmental Sciences' AIDS/STD Program at 444-4740.

RESOURCES

1990 Aids Conference

The 1990 Montana Conference on AIDS will be held March 22 and 23, 1990 at the Strand Union Building on the Montana State University campus in Bozeman. This is the second AIDS conference held in the state.

AIDS remains one of the most serious health problems facing this country and the world. Already over 150,000 cases of AIDS have been reported from nearly 150 countries around the world. The 1990 conference hopes to focus on some of the important issues of the epidemic.

The conference has been arranged in such a way that workshops on a variety of topics will be offered. Local, state and nationally known presenters will participate.

Dr. William Valenti will address the general session in a presentation entitled "AIDS: Diagnosis and Treatment Update". He will also be doing a workshop session in the afternoon. Dr. Valenti is a nationally recognized expert in this field.

Friday's session will feature Tim Westmoreland, aide to Senator Henry Waxman, who will cover the latest Congressional happenings. Also featured Friday is Dr. James Allen, who is the Director of CDC's HIV Prevention Program. His presentation will cover current CDC focus, including short term and long term goals and the current status of the epidemic.

The conference is a cooperative effort between several participants and is being financially assisted by Blue Cross/Blue Shield, Area Health Education Center, Montana Department of Health and Environment Sciences, Office of Public Instruction and Burroughs Wellcome. The cost for the two-day conference is $30.00 or $20.00 for one day. For more information, contact MDHES at 444-4740 or AHEC at 994-6001.

*MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 12/1/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	25 (45)	14 (57)
Other Disease w/o PCP	26 (49)	15 (60)
KS Alone	3 (6)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	54 (100)	29 (55)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	16 (29)
30-39	24 (45)
40-49	9 (16)
Over 49	5 (10)
Unknown	0 (0)
Total	54 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	49 (90)
Black, Not Hispanic	1 (2)
Hispanic	2 (4)
Native American	2 (4)
Unknown	0 (0)
Total	54 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	32 (64)	0 (0)	32 (59)
Intravenous (IV) Drug User	6 (13)	0 (0)	6 (12)
Homo/Bi IV Drug User	6 (11)	0 (0)	6 (10)
Hemophiliac	3 (6)	0 (0)	3 (6)
Heterosexual Contact	0 (0)	3 (75)	3 (6)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (6)	1 (25)	4 (8)
Total	54 (100)	4 (100)	54 (100)

Source: Montana AIDS Program, MDHES, December 1, 1989

*Includes 39 Montana AIDS cases and 15 cases reported to Centers for Disease Control from other states who are living in Montana.

As of November 30, 1989 there have been 229 positive HIV tests from 17,785 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of October 31, 1989, 112,241 cases of AIDS and 66,493 deaths have been reported to the Centers for Disease Control.

The current caseload of AIDS include 49 white, not Hispanic; 2 American Indian; 2 Hispanic; and 1 black for a total to December 1, 1989 of 54 cases.

DK/war-xt

NOVEMBER 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1													
Big Horn		4	1	5		1									
Blaine															
Broadwater															
Carbon		1													
Carter															
Cascade		12	1	1				1							
Chouteau															
Custer		1		1							1				
Daniels															
Dawson		2		3											
Deer Lodge		1	2	1											
Fallon															
Fergus		1													
Flathead			3	2		1									
Gallatin		18	4				1								
Garfield		1													
Glacier		4											3		
Golden Valley															
Granite															
Hill		3				1	1				1			1	
Jefferson				1											
Judith Basin															
Lake		3		2		3									
Lewis & Clark		9		4			1								
Liberty															
Lincoln		2													
McCone															
Madison															
Meagher															
Mineral															
Missoula		20	2											1	
Musselshell															
Park															
Petroleum	1		1												
Phillips															
Pondera															
Powder River															
Powell															
Prairie															
Ravalli															
Richland															
Roosevelt		5		4										3	
Rosebud		2	1												
Sanders															
Sheridan															
Silver Bow		3		1											
Stillwater															
Sweet Grass															
Teton			1									1			
Toole															
Treasure															
Valley		1													
Wheatland															
Wibaux															
Yellowstone		17	1	3									6		
MONTHLY TOTAL 19 89	1	111	17	32	0	6	3	1	0	0	2	1	9	5	0
MONTHLY TOTAL 19 88	8	150	7	36	1	3	7	0	0	0	4	12	4	24	12
MONTHLY TOTAL 19 87	2	*N/A	17	44	1	6	4	0	0	0	8	20	3	1	4
TOTAL TO DATE 19 89	91	1284	169	209	9	88	44	6	3	4	85	70	85	100	17
TOTAL TO DATE 19 88	79	1784	191	378	10	39	53	10	4	1	86	102	89	212	31
TOTAL TO DATE 19 87	35	*N/A	152	558	18	86	50	9	3	4	116	125	71	28	15

OTHER DISEASES: Chickenpox: Cascade, 1; Yellowstone, 1; Cytomegalo Viral Illness: Chouteau, 1; Gallatin, 1; Missoula, 1; Yellowstone, 1; Pertussis: Cascade, 2; Syphilis, Primary: Sweetgrass, 1; Syphilis, Late Latent: Beaverhead, 1

*Chlamyda numbers for November, 1987 will be added to December, 1987 numbers.

Amantadine Prophylaxis Recommendations

Amantadine is recommended under certain circumstances, particularly for control of presumed influenza A outbreaks in institutions housing high risk persons. Chemoprophylaxis should begin as early as possible after the outbreak is recognized. Contingency planning is needed in chronic care facilities to establish specific steps for rapidly administering amantadine to residents and staff when influenza outbreaks occur. For outbreak control, amantadine should be administered to all residents of the institution whether or not they received influenza vaccine the previous fall. Amantadine should also be offered to unvaccinated staff who provide care to high risk patients for prophylaxis, the antiviral drug should be taken each day for the duration of influenza activity in the community. Amantadine prophylaxis is also recommended in the following situations: 1) As an adjunct to late vaccination of high risk persons. It is not too late to vaccinate even when influenza A is known to be in the community. However, because the development of an antibody response following vaccination takes about two weeks, amantadine should be used during this period. Amantadine does not interfere with the antibody response to the vaccine. 2) To reduce the spread of infection and to maintain care for high risk persons in the home. Unvaccinated persons who provide home care for high risk persons (e.g., household members, visiting nurses, volunteer workers) should also receive amantadine prophylaxis during the period when influenza A outbreaks occur. 3) For immunodeficient persons. As a supplement to the protection afforded by vaccination, amantadine prophylaxis is indicated for high risk patients who may have a poor antibody response to influenza vaccine, such as persons with AIDS. Whereas adults with AIDS can be expected to have some residual immunity to influenza from prior infections, children with AIDS may have little or no immunity to the virus. Therefore, amantadine prophylaxis against influenza should be considered during influenza epidemics, especially for children with AIDS. The potential benefits should be evaluated on a case by case basis, taking into account the potential risk of side effects, especially in patients with central nervous system involvement. 4) For persons for whom influenza vaccine in contraindicated (see Side Effects and Adverse Reactions, pp 306-307, MMWR, May 5, 1989/Vol. 38/no. 17). Amantadine can also be used prophylacticly in other institutions (e.g., for unimmunized members of the general population who wish to avoid influenza A illness). This decision should be made on an individual basis.

ACIP Centers for Disease Control, Atlanta, Georgia 30333.

Gonorrhea in Homosexually Active Men -- Washington

It was reported in the November 10, 1989 issue of Morbidity/Mortality Weekly Report that gonorrhea cases in homosexually active men in King County, Washington may triple in 1989 from 1988. Health officials there have no direct explanations for the increase in cases, although they suspect it may have been due to introduction of the disease into subpopulations who have never adopted safer sex practices or that the frequency of high risk behavior may have increased. This increase follows years of declining gonorrhea incidence generally. The decline in gonorrhea trends in recent years in homosexual and bisexual men has been considered to reflect changes in sexual behavior in response to the AIDS epidemic.

Montana has observed a similar decline in total gonorrhea cases since 1980. But in reviewing case reports for 1988 and 1989 no increase or decrease can be observed attributable to same sex behavior. The site of infection in the 168 male cases reported in 1988 was available on 161 cases, none of which showed rectal or pharyngeal infected sites. Of the 85 male cases reported during the first 9 months of 1989, 77 had site of infection listed, of which none were positive for rectal or pharyngeal gonorrhea.

This absence of rectal or pharyngeal GC in males may be due to a decline in disease occurrence in homosexual or bisexual men, incomplete or inaccurate reporting, or failure to culture appropriate sites of infection.

Recommendations for Penicillin-Resistant Gonorrhea

A gonorrhea culture collected from a patient in eastern Montana in November was confirmed as a penicillinase-producing N. gonorrhoeae (PPNG) by the State Public Health Laboratory in Helena. These organisms are resistant to treatment with penicillin and are normally detected in the laboratory by routinely testing N. gonorrhoeae isolates for beta-lactamase production. This is the 17th confirmed case of PPNG reported in Montana since 1981 and the 6th reported without a confirmed source identified. Two of the four cases reported in 1989 had no source identified and three of the four cases were from eastern Montana. The increasing prevalence of resistant strains of Gc are shown in Figure 8. Following are recommendations for control of PPNG in Montana:

1. Do cultures and direct smears on all exposed sites for gonorrhea from male or female patients. (Patients with a history of travel within 60 days to foreign or domestic areas of high prevalence of PPNG, or with recent exposure to prostitutes are at increased risk of contracting a resistant strain.)

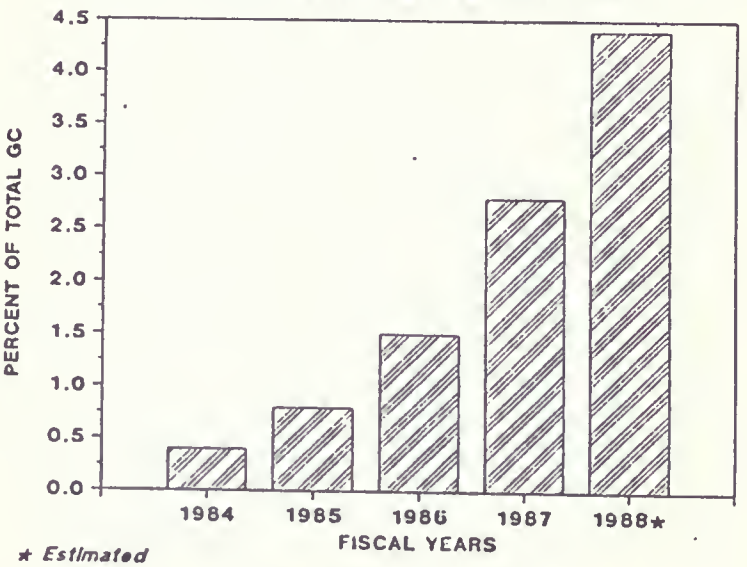
2. Ensure that any gonorrhea cultures are tested for beta-lactamase production. Refer all beta-lactamase positive cultures to the Montana Public Health Laboratory.

3. Treat all gonorrhea patients and any uncultured contacts with the newly recommended therapy of 250 mg. ceftriaxone, 2 g. spectinomycin or other medications included in the 1989 STD Treatment Guidelines from the Centers for Disease Control, followed by doxycycline. If the patient's culture has tested negative for beta-lactamase, therapy such as 3 gm amoxicillin or 3.5 gm ampicillin may be substituted, followed by doxycycline. The initial higher costs of these medications is offset by the declining need for a follow-up culture (test-of-cure).

4. Report all cases immediately to your local health department.

Of the 147 cases of gonorrhea reported during the first 9 months of this year, 57 or 39% were treated with either ceftriaxone or spectinomycin. If you have any questions, you may call your local health department or the Montana STD Program at 444-4740.

Figure 8. Resistant Strains as Percent of Total GC
United States, Fiscal Years 1984 - 1988



Viral Hepatitis Case Report Forms To Change

MDHES has received notification from the Centers for Disease Control that the Viral Hepatitis Case Report is to be changed as of January 1, 1990. This form is a multi-copy form where detailed information about each case of hepatitis is recorded and has been used for approximately 15 years in various revisions.

MDHES has not received a supply of the new forms and we probably won't until late in December. As soon as you receive the new forms from us, please quit using the old forms and throw them away. We will be sending you the new forms and any information you need to use them in the near future.

FDA Warning on Idaho's Naturopath's "Immunization Kits"

In November, the Food and Drug Administration warned that an Idaho naturopath's "immunization kits" sold widely through the mails to protect children from common diseases consisted of alcohol and water solutions and sugar pills.

The immunization kits may have been sold as protection from polio, scarlet fever, smallpox, measles, typhoid, mumps, tetanus, whooping cough and diphtheria.

FDA said copies of letters of immunization signed "Dr. James Solomon, N.D." were found. The agency said such letters signed by Solomon or other naturopaths may have been sent to kit purchasers so they could get their children into schools, most of which require vaccination against contagious diseases.

"FDA has never approved immunization kits or vaccines for use in the home," FDA Commissioner Frank E. Young, M.D., Ph.D., said. "Parents who may have bought and used such unapproved kits should have their children immunized as soon as possible. These kits and pills offer no protection."

The kits were discovered when a team led by the Idaho State Attorney General's Office executed search and seizure warrants October 25 and 26 at the Twin Falls office, laboratory and health food stores of J.S. Inc., and the distribution company of James D. Solomon, and the E.F. Skilling Company of Buhl, Idaho, a device manufacturer. Solomon has referred to himself as a "naturopath," a term sometimes used by people who recommend "natural" therapies. Some of the produces are also labeled "Homeopathic." FDA participated in the investigation.

Records of distribution of J.S. Inc. products were in disarray. But distribution was apparently to naturopaths and parents as well as regional distributors. While the kits may have been sold in every state, the records reviewed so far establish sales to Florida, Utah, Ohio, Kansas, South Carolina, Washington and Wyoming.

FDA warned that Solomon also appears to have promoted tinctures, pellets and unapproved medical devices as treatments for AIDS, angina, bone marrow suppression, cancer, Down's syndrome, epilepsy, cataracts, hemophilia, diabetes, multiple sclerosis, Parkinson's disease, rabies, tuberculosis and various tumors.

Idaho authorities said that Solomon has been arrested on state charges. FDA will continue to investigate the distribution of these unapproved products.

While most of the products sold in the immunization kits have counterparts in medicine, there is no valid vaccine for scarlet fever, and smallpox vaccine is no longer given since that disease has been eradicated worldwide.

Inactivated Polio Vaccine Available at Cost

Park Clinic in Livingston, MT has five 1 ML vials of IPV (Human Diploid) for sale at their cost of $72.35. Expiration date on the vaccine is 8/24/90. If interested in purchasing it from them, please contact Rose TeBest at (406) 222-0800.

A Case of Neonatal Tetanus in Martin County, Florida

Florida's Department of Health and Rehabilitative Services reports that a case of neonatal tetanus in an 8-day-old baby girl was diagnosed and successfully treated in Martin County, Florida in May 1989. The Martin County case represents the first case to be reported to the Centers for Disease Control since 1984. From 1972-1984, 29 cases were reported to CDC.

The baby was brought to a hospital emergency room on May 18 for irritability, rigidity, difficulty in breathing, cyanotic spells and the inability to suck. On examination, the child had a dusky color, trismus and a malodorous discharge from the umbilicus.

The baby had been delivered at home to a 27-year-old Guatemalan woman. The delivery was assisted by an aunt, who cut the umbilical cord with unsterilized scissors and used water to clean the cord. The mother had received no prenatal careand had not been immunized for tetanus. She did not attend school in Guatemala, where children usually receive immunization. She has been living in the United States since 1985 and has worked in various South Florida counties as a seasonal migrant worker.

On the basis of case history and laboratory findings, a diagnosis of neonatal tetanus was made. The baby was treated with tetanus immune globulin (TIG) intramuscularly in the emergency room and was transferred to a hospital with a neonatal intensive care unit. There she received various sedatives and antibiotics, including penicillin, claforan and ampicillin, and additional TIG.

The baby was discharged 26 days later in good condition. Both mother and infant have been started on their primary series of immunizations for tetanus and diphtheria.

Condensed from Epi-Gram, Vol. 10, Issue 5, September 1989.

Give One ML Human Diploid Cell Vaccine to Travelers Taking Chloroquine

Chloroquine phosphate (administered for malaria chemoprophylaxis) and other unknown factors encountered by persons traveling to developing countries may interfere with the antibody response to HDCV. The intramuscular (IM) dose/route of pre-exposure prophylaxis, however, provides a sufficient margin of safety in this setting. HDCV should not be administered by the intradermal (ID) dose/route when chloroquine or other drugs which may interfere with the immune response are being used.

Volume: 13:12 **Month of:** November, 1989

MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

POSTMASTER: Send address changes to Montana Morbidity Report, Cogswell Building, Helena, MT 59601

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VOLUME: 13:13 MONTH OF: Dec., 1989

Montana State Department of Health and Environmental Sciences

* *
* HIV/AIDS INFORMATION *
* *

The Montana Department of Health and Environmental Sciences announces that the Montana AIDS/STD Program had received a $30,000 grant from the U.S. Department of Health and Human Services for the AIDS Drug Reimbursement Program (ADRP). The money will be used to cover the cost of azidothymidine (AZT) to prolong and improve the life of a person with acquired immunodeficiency syndrome (AIDS).

Program assistance will be made available to individuals who meet eligibility requirements which include:

- -- Severe economic imbalance
- -- Having AIDS or being HIV-positive
- -- Physician certification that the patient will benefit from the administration of AZT
- -- Ineligible for Medicaid
- -- Utilize and exhaust any other third-party benefits

Priority consideration for enrollment in the Montana ADRP will be given to persons previously enrolled in the program. Enrollment in the program will be limited to the number of participants the program can support with funds available for the grant period. Applications will be reviewed and eligibility determined in the order applications are received.

An application form may be requested from the Montana AIDS/STD Program, Department of Health and Environmental Sciences, Helena. For questions, contact Andrea Baumgardner, Montana AIDS Project, 444-4740.

PROGRAM CHANGES

The Montana AIDS/STD Program is undergoing major changes in staff. Cathy Silva has taken a new job with the Lewis and Clark City-County Health Department. Rick Chiotti, Program Manager, is leaving after 3 1/2 years of dedicated service in the AIDS Program. He has accepted a job with the Office of Public Instruction to administer 2 federal grants dealing with AIDS Education and Drug-Free schools.

A new staff person was hired by the AIDS/STD Program. Rhonda Boyle previously worked with the Montana Perinatal Program and recently graduated from Carroll College with a B.A. in medical records administration. Her new position as a health educator will involve health education, risk reduction and public information services.

CONFERENCES

1990 Aids Conference

The 1990 Montana Conference on AIDS will be held March 22 and 23, 1990 at the Strand Union Building on the Montana State University campus in Bozeman. This is the second AIDS conference held in the state.

AIDS remains one of the most serious health problems facing this country and the world. Already over 150,000 cases of AIDS have been reported from nearly 150 countries around the world. The 1990 conference hopes to focus on some of the important issues of the epidemic.

The conference has been arranged in such a way that workshops on a variety of topics will be offered. Local, state and nationally known presenters will participate.

Dr. William Valenti will address the general session in a presentation entitled "AIDS: Diagnosis and Treatment Update". He will also be doing a workshop session in the afternoon. Dr. Valenti is a nationally recognized expert in this field.

Friday's session will feature Tim Westmoreland, aide to Senator Henry Waxman, who will cover the latest Congressional happenings. Also featured Friday is Dr. James Allen, who is the Director of CDC's HIV Prevention Program. His presentation will cover current CDC focus, including short term and long term goals and the current status of the epidemic.

The conference is a cooperative effort between several participants and is being financially assisted by Blue Cross/Blue Shield, Area Health Education Center, Montana Department of Health and Environment Sciences, Office of Public Instruction and Burroughs Wellcome. The cost for the two-day conference is $30.00 or $20.00 for one day. For more information, contact AHEC at 994-6001.

RESOURCES

Robert Wood Johnson Grant Guide available free. Write RWJ Foundation, Box 2613, Princeton, NJ 08543-2326.

AIDS Foundation Houston (AFH) has produced two new 30-minute video tapes for minorities. "Unidos Contra el Sida", and "AIDS: It's a Black Problem, Too". Contact AFH, 3927 Essex Lane, Houston, TX 77027, (713) 623-6796.

The National Institute of Allergy and Infectious Diseases (NAIAD) has established a NIAID AIDS Clinical Trials Information Service. The computerized service provides current information, free of charge, about clinical trials sponsored by the National Institutes of Health (NIH) for AIDS patients and other infected with the human immunodeficiency virus (HIV). Callers may reach the service by dialing 1-800-TRIALS-A, Monday through Friday between 9:00 a.m. and 7:00 p.m., e.d.t.

Class Offering

The Montana Department of Health and environmental Sciences, AIDS Program, announces a date for the next HIV Counselor Course. The course will be offered February 14 and 15 in Helena. This course is being offered to provide training for people involved in counseling persons who request the HIV test. For more information call Andrea Baumgardner at 444-4740.

Communicable Disease Fact Sheets Now Available

For the past year, the Communicable Disease section of MDHES has been working on a set of communicable disease fact sheets. This was done in response to county health departments expressing to us a desire to have information for the general public about communicable diseases. The basis for the communicable disease fact sheets is a set developed by New York State. The development of the Montana set is being done in two stages. The communicable disease fact sheets now available are ones for the following diseases: amebiasis, arboviral infections, botulism, brucellosis, campylobacteriosis, chancroid, chicken pox, chlamydia (genital infection), diphtheria, fifth disease, genital warts, giardiasis, gonorrhea/gonococcal infection, haemophilus influenza B disease, hepatitis A, hepatitis B, hepatitis non-A non-B, herpes II, legionellosis, Lyme disease, malaria, measles, meningococcal meningitis, mumps, non-gonococcal urethritis, pediculosis, pertussis, plague, polio, psittacosis, rocky mountain spotted fever, rubella, salmonellosis, scabies, shigellosis, swimmers itch, syphilis, tetanus, tuberculosis, tularemia and viral meningitis. Sets of these fact sheets will be sent to county health departments in the near future.

Other diseases for which fact sheets will still be developed are ones which are less common. The fact sheets for less common diseases will be available for duplication when occasional cases occur. A list of the diseases for which the duplicatable fact sheets will be available will be given to you in a later issue of this publication.

*MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - 12/1/89 to 12/31/89

1. Disease Category	Adult/Adolescent Cases (%)	Deaths (%)
PCP	28 (49)	18 (51)
Other Disease w/o PCP	26 (46)	17 (49)
KS Alone	3 (5)	0 (0)
No Diseases Listed	0 (0)	0 (0)
Total	57 (100)	35 (100)

2. Age	Cases (%)
Under 13	0 (0)
13-19	0 (0)
20-29	18 (32)
30-39	25 (43)
40-49	9 (16)
Over 49	5 (9)
Unknown	0 (0)
Total	57 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)
White, Not Hispanic	52 (90)
Black, Not Hispanic	1 (2)
Hispanic	2 (4)
Native American	2 (4)
Unknown	0 (0)
Total	57 (100)

4. Patient Groups	Adult/Adolescent Males (%)	Females (%)	Total (%)
Homosexual or Bisexual Men	34 (64)	0 (0)	34 (59)
Intravenous (IV) Drug User	6 (12)	0 (0)	6 (11)
Homo/Bi IV Drug User	6 (12)	0 (0)	6 (11)
Hemophiliac	3 (6)	0 (0)	3 (5)
Heterosexual Contact	0 (0)	4 (80)	4 (7)
Transfusion With Blood/ Products	0 (0)	0 (0)	0 (0)
None of the Above/Other	3 (6)	1 (20)	4 (7)
Total	52 (100)	5 (100)	57 (100)

Source: Montana AIDS Program, MDHES, through December 31, 1989.

*Includes 41 Montana AIDS cases and 16 cases reported to Centers for Disease Control from other states who are living in Montana.

As of December 31, 1989 there have been 236 positive HIV tests from 18,211 tests conducted through the MDHES Public Health Laboratory.

Nationally, as of November 30, 1989, 115,158 cases of AIDS and 68,441 deaths have been reported to the Centers for Disease Control.

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HIV Seroprevalence Surveys: Child Bearing Women

The following are some excerpts from the Centers for Disease Control guidance documents related to HIV seroprevalence surveys in child bearing women. Montana Department of Health and Environmental Sciences Public Health Laboratory has been conducting such a study on an ongoing basis since fall of 1988. There have been no positive specimens reported from the Public Health Laboratory thus far.

As part of the Comprehensive Family of Surveys to obtain estimates of human immunodeficiency virus (HIV) seroprevalence in the United States, surveys to measure the levels and trends of HIV infection in women bearing live children were planned for 30 metropolitan areas and the states which contain those areas. The sampling and testing of neonatal blood specimens, routinely collected on filter paper for state neonatal metabolic screening programs, are being used to provide representative, unbiased estimates of HIV seroprevalence in child bearing women. The basis of this approach is that maternal antibody to HIV is passively transferred across the placenta to the fetus and, therefore, is present in the blood of the newborn at approximately the same concentration as in the mother. The surveys were targeted to begin nationwide in July of 1988 and have been continuing since then.

The Massachusetts Public Health Department, under a contract with the National Institutes of Health, developed the technology to test neonatal blood absorbed to specimen collection paper used in neonatal screening programs for maternal antibody to HIV by immunofluorescent antibody assay (IFA), enzyme-linked immunosorbent assay (ELISA, EIA), and western blot (immunoblot). From December 1986 to April 1987, Massachusetts tested 20,086 specimens. Adjusting the results of the sample to reflect the overall population of live births in the state and assuming 100% concordance in the antibody detection in mothers and infants gave a seropositivity rate of 2.2 cases per 1000 women for the five month period.

These findings were startling to members of the public health community. Therefore, an emphasis on repetition of such studies in other states was made by Centers for Disease Control.

The objective of such a survey is to obtain relatively unbiased estimates of the levels and trends of HIV infection in the population of child bearing women in the United States. The secondary objectives will be achieved by testing neonates for passively transferred maternal antibodies to HIV. Information from these surveys should (1) fulfill local public health planning and evaluation needs, (2) meet the national surveillance responsibilities of the Centers for Disease Control and (3) meet the HIV epidemiologic research needs of the National Institutes of Health. These serologic surveys should not be used in lieu of prenatal/neonatal screening and testing and counseling programs. All women of child bearing age with identifiable risk for HIV infection should be routinely counseled and tested for HIV independently of and concurrent with the conduct of these surveys. Counseling and testing should be provided to women during family planning visits as part of prenatal health care programs or at the delivery.

Eosinophilia-Myalgia Syndrome Associated with Ingestion of L-Tryptophan

Montana Department of Health and Environmental Sciences, Communicable Disease Section in the Cogswell Building, Helena, MT 59620 is receiving frequent communications from Centers for Disease Control regarding the above named syndrome. CDC has distributed information for physicians being called upon to treat patients with the syndrome. The information available includes description of studies being conducted (by state), demographic data for cases, symptoms, case descriptions and definition, serum and urine collection procedures, etc. If physicians or other professionals are in need of this information, please contact the MDHES at the above address or by calling 444-4740 and asking for the Communicable Disease Section.

The following information is excerpted in part, from a CDC "Update Briefing" dated 12/22/89 and MMWR V.38, No. 46, 11/24/89.

Case Reports

As of 1:00 p.m. on 12/22/89, 971 cases had been reported to the CDC from state and territorial health departments.

AL - 9	LA - 1	OH - 44
AK - 0	ME - 3	OK - 18
AZ -26	MD - 19	OR - 59
AR - 4	MA - 9	PA - 31
CA - 183	MI - 6	RI - 3
CO - 25	MN - 60	SC - 11
CT - 8	MS - 9	SD - 0
DE - 2	MD - 19	TN - 8
DC - 3	MT - 2	TX - 43
FL - 55	NE - 6	UT - 5
GA - 21	NV - 5	VT - 1
HI - 2	NH - 8	VA - 7
ID - 6	NJ - 6	WA - 34
IL - 28	NM - 22	WV - 8
IN -11	NY - 92	WI - 17
IA - 5	NC - 18	WY - 3
KS - 1	ND - 1	PR - 3
KY - 2		

Another death of a patient with EMS who had been taking L-tryptophan was reported by California yesterday; the details of the case history and autopsy results for this case are still pending. This brings the total to five deaths of EMS patients who have been taking LT, but only one of these has been confirmed as directly attributable to EMS.

Preliminary Analysis of Surveillance Data

We conducted a preliminary analyses on the first 235 case reports received. Ages of patients ranged from 14 to 76 years, with a median of 46; 97% were white, 2% black and 1% were Hispanic. 83% were female. 99% had a history of L-tryptophan ingestion preceding the onset of symptoms and dosage ranged from 50 to 18,000 mg/day, with a median dosage of 1,500 mg/day. 88% reported onset of symptoms during or after July 1989 and 39% had required hospitalization.

Frequency of Symptoms

Myalgia (usually severe)	100%
Eosinophilia _1000/mm3	100%
Leukocytosis	87%
Arthralgia	67%
Cough or dyspnea	61%
Rash	60%
Fever	58%
Edema of extremities	49%
Elevated liver enzymes*	44%
Periorbital edema	29%
Neuropathy or neuritis**	20%
Sclerodermiform skin changes	20%
Alopecia	13%

*Although liver enzymes were elevated in 44% of patients tested, hepatomegaly (5%) and splenomegaly (1%) were rarely reported.

**Has resulted in paralysis to some degree and one case death. In the fatal case, clinical manifestations involved a severe ascending polyneuropathy with near total quadriplegia and a bifacial hemiparesis.

We emphasize that these data represent a preliminary analysis of a small proportion of total cases reported, but they are suggestive of the multi-systemic nature of EMS and its potential for severe, long-term sequelae.

In addition to the significant hospitalization rate noted above (39%), we continue to receive many verbal reports from clinicians stressing the severity of myalgias and resulting limitations of function in their patients. Also, steroids appear to provide only a modest improvement in symptoms and when they have been helpful it is apparently difficult to wean the patients from them without symptoms recurring. We hope that the study of early patients (i.e., those whose illness started between 1986 and June 1989) will provide a more detailed and comprehensive view of the natural history and response to treatment in these patients.

A recent CDC bulletin indicates that the search for contaminant(s) continues, but none have been identified.

DECEMBER 1989	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1													
Big Horn		3	1									1			2
Blaine															
Broadwater															
Carbon															
Carter															
Cascade		9		2			1								2
Chouteau															
Custer				1											
Daniels															
Dawson															
Deer Lodge			4												
Fallon															
Fergus		1													
Flathead	1	5	1				1								
Gallatin	1	16	2	2			1								
Garfield															
Glacier		10		2											1
Golden Valley															
Granite															
Hill		5				1	3								
Jefferson															
Judith Basin															
Lake		4			1										1
Lewis & Clark		6											2		
Liberty															
Lincoln		3													
McCone															
Madison															
Meagher															
Mineral															
Missoula		9	1	1											
Musselshell															
Park															
Petroleum															
Phillips															
Pondera															
Powder River															
Powell															
Prairie															
Ravalli	1	2													
Richland															
Roosevelt		6	1	2								1		5	2
Rosebud															2
Sanders		1													
Sheridan															
Silver Bow		3													1
Stillwater		1													
Sweet Grass															
Teton				1											
Toole															
Treasure															
Valley												1			
Wheatland															
Wibaux															
Yellowstone		21		4									4		4
MONTHLY TOTAL 1989	3	106	10	15	1	1	6	0	0	0	0	3	6	5	15
MONTHLY TOTAL 1988	5	150	13	32	0	8	3	0	0	0	9	10	8	49	7
MONTHLY TOTAL 1987	4	*308	24	58	1	1	9	2	2	0	6	20	3	14	7
TOTAL TO DATE 1989	94	1390	170	224	10	89	50	6	3	4	85	73	91	105	31
TOTAL TO DATE 1988	84	1934	204	410	10	47	56	10	4	1	95	112	97	261	38
TOTAL TO DATE 1987	39	1754	176	616	19	87	59	11	5	4	122	145	74	42	22

OTHER DISEASES: Chickenpox: Cascade, 1; Hill, 10; Cytomegalo Viral Illness: Cascade, 1; Missoula, 2 E.Coli0157:H: Lewis & Clark, 1; Kawasaki: Gallatin, 1; Pertussis: Lake, 1; Park, 3

DELETIONS: from 1989 yearly totals, delete 9 Giardia and 1 Tuberculosis (1989 totals to date reflect the deletions)

* Monthly Chlamydia totals for 1987 are for Nov. & Dec. combined

Attention: Vaccine Contractees and Immunization Clinic Managers

Recent immunization clinic "reviews" conducted throughout the state have disclosed that many immunization programs are not in possession of some important documents which are needed for operation.

Many of the items listed below are necessary for operating in compliance with the vaccine contract. Please review the following list and contact the Immunization Program at 444-4740 in Helena, to fill any shortages you may have.

Vaccine Contract Attachments

A. Important Information Forms:
   1. Polio (3/1/83)
   2. DPT/DT/Td (1/1/88)
   3. Measles, Mumps, Rubella (1/1/88)
   4. Haemophilus b Conjugate (6/1/89)

B. Instructions - Immunization Record and Signature Card (file card)

C. Official Montana Immunization Record (wallet card)

D. Vaccine Reaction Telephone Log (HES-111; flip side of I below)

E. Report of Adverse Event Following Immunization (CDC/71.19)

F. Temperature Monitoring Log (HES-115)

G. Vaccine Order Blank (HES-115)

H. Vaccine Shipment Receipt Form (HES-110)

I. Vaccine Report Form (HES-111; flip side of D above)

J. Clinic Review Form (HES-116)

K. Refrigeration Recommendations (large pink poster)

L. Recommendations for Handling and Storage of Selected Biologicals

Other Materials

1. Placard: Vaccine not denied due to inability to pay
2. Sample standing medical orders
3. Booklet: Parents Guide to Immunization (1/88)
4. Hib Conjugate Vaccine pamphlet (Praxis Biologics developed)
5. Pneumoccal pneumonia vaccine pamphlet (Lederle Biologics developed)
6. Pamphlet: Immunizations: A Gift That Can Last a Lifetime (DHES developed)

Volume: 13:13 **Month of:** December, 1989

MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

POSTMASTER: Send address changes to Montana Morbidity Report, Cogswell Building, Helena, MT 59601

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1200 copies of this public document are published monthly at an estimated cost of 37¢ per copy, for a total cost of $435.00, which includes $300.00 for printing and $135.00 for distribution.

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1989 ANNUAL SUMMARY

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		16		1							2				
Big Horn		31	2	16	1	3	2				1	6		12	3
Blaine		20	1	3											
Broadwater		3													
Carbon		4									6	9	2		
Carter															
Cascade	2	186	20	37		1	4	1	1		4	8	5		3
Chouteau		4	3												
Custer		26		3							1	2			
Daniels												1			
Dawson	1	17		4							4	2	4		
Deer Lodge	1	8	9	1							1		1		
Fallon			1								1				1
Fergus	3	9	4	1							7	5	1	1	
Flathead	6	39	17	8		6	5	3	1		5	2	4	1	2
Gallatin	10	203	20	9	1	5	3	1			6		5		
Garfield		1										1			
Glacier	2	66	4	23							2		6	47	4
Golden Valley															
Granite			1												
Hill		45	5			18	5				2		2	2	
Jefferson	2			1											
Judith Basin												2			
Lake	1	30	2	5	3	18	2				1		1	1	
Lewis & Clark	5	124	8	14		4	10				5		8	1	
Liberty															
Lincoln	3	28	1	2							1	1			
McCone		1										2		1	
Madison	3	1								1				1	
Meagher				1	1										
Mineral		1													
Missoula	18	116	23	8	3	26	10	1			2		4	4	
Musselshell		2	2								6	5			
Park	2	7	2								2			2	
Petroleum	2		1												
Phillips		5										1	1		
Pondera	1		1								2	1			
Powder River		1									1				
Powell		8		2											
Prairie	1														
Ravalli	1	12	3	2							1	1			
Richland		2		3			1								
Roosevelt	1	48	6	29							6	2	1	17	6
Rosebud	1	21	3	6		2					3	1	1	9	3
Sanders		5				1									
Sheridan		1									1				
Silver Bow	7	47	9	9	1	2	1			1	1	1	4		1
Stillwater		4	1			1					1	1			
Sweet Grass	3	4	2			2									
Teton		1	5	2								3			
Toole			1								1	3			
Treasure															
Valley	3	4									1	4			1
Wheatland		1									2	2			
Wibaux	1	1													
Yellowstone	14	238	14	35		2	7	1	1		5	8	44	6	5
Yearly Totals 19 89	94	1391	171	225	10	88	50	7	3	2	85	73	93	105	31
Yearly Totals 19 88	83	1958	203	421	10	47	55	10	4	1	95	214	96	261	39
Yearly Totals 19 87	39	1775	177	619	18	86	59	11	5	4	121	185	74	42	21

**GONOCOCCAL DISEASE TOTALS:
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FLATHEAD - 1
GALLATIN - 2
JEFFERSON - 1
LEWIS & CLARK - 1
VALLEY - 1

BACTERIAL MENINGITIS UNSPECIFIED - 1

JEFFERSON - 1

BRUCELLOSIS - 1

DEER LODGE - 1

CHICKENPOX - 394

CASCADE - 34
DAWSON - 16
GALLATIN - 10
HILL - 27
LEWIS & CLARK - 11
MADISON - 48
MEAGHER - 2
PARK - 10
SILVER BOW - 11
YELLOWSTONE - 225

COLORADO TICK FEVER - 12

BEAVERHEAD - 2
BIGHORN - 1
GALLATIN - 1
MISSOULA - 5
PARK - 2
YELLOWSTONE - 1

CYTONEGALO VIRAL ILLNESS - 18

CASCADE - 5
CHOTEAU - 1
CUSTER - 1
GALLATIN - 1
MISSOULA - 8
YELLOWSTONE - 2

E. COLI. 0157:H7 - 6

CASCADE - 1
FLATHEAD - 1
LEWIS & CLARK - 2
MISSOULA - 2

LEGIONELLOSIS - 3

CASCADE - 2
GALLATIN - 1

LEPROSY - 1

YELLOWSTONE -1

MALARIA - 1

GALLATIN - 1

MEASLES, INDIGENOUS - 12

FLATHEAD - 12

MEASLES IMPORTED - 1

FLATHEAD - 1

MUMPS - 4

GALLATIN - 4

PERTUSSIS - 43

CASCADE - 3
FLATHEAD - 1
GALLATIN - 3
HILL - 1
LAKE - 1
PARK - 29
SILVER BOW - 2
YELLOWSTONE - 3

ROCKY MOUNTIAN SPOTTED FEVER - 15
CASCADE - 1
DAWSON - 1
LEWIS & CLARK - 1
MCCONE - 1
MISSOULA - 4
RAVALLI - 4
WHEATLAND - 1
YELLOWSTONE - 1

RUBELLA - 1

MISSOULA - 1

SYPHILIS, PRIMARY - 2

BIG HORN - 1
SWEET GRASS - 1

SYPHILIS, EARLY LATENT
UNDER 1 YR. - 5

CASCADE - 2
GLACIER - 1
YELLOWSTONE - 2

SYPHILIS, LATE LATENT - 5

BEAVERHEAD - 1
CASCADE - 1
POWELL - 1
MUSELSHELL - 1
STILLWATER - 1

TULAREMIA - 1

BIG HORN - 1

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Volume: 1989 ANNUAL SUMMARY

ISSN #0745-5129

MONTANA MORBIDITY REPORT. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620.
Distributed without charge to health care providers at a cost of 6¢ per copy for printing and 7¢ per copy mailing.